The Bulletin

MEDICAL SOCIETY OF PIERCE COUNTY

In This Issue . . .

January, 1984

Cover Photo: See Society News Briefs, page 4

"After a year-long search, we chose Poorman-Douglas. Again."

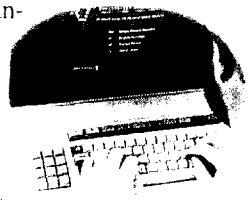
Three years ago, Vancouver Clinic made the changeover to an in-house computer, the MED990 System from Poorman-Douglas.

Says Administrator Roger Garretson, "We spent over a year talking to suppliers, making sure we had the right system. We wanted local capability in software and local service in hardware."

Perhaps most important, Vancouver Clinic preferred both hardware and software to be supplied by one company. "We were interested in a good working relationship, not in trying to decide whose responsibility it was if something went wrong."

Why Poorman-Douglas.

"We'd already built up a good relationship with them – they'd done an excellent job as our service bureau for 12 years." Best of all, Poorman-Douglas designs its own software expressly for medical applications, and features hardware by Texas Instruments.



"The combination of Poorman-Douglas and Texas

Instruments, plus our own preplanning, made for an excellent, cost-effective system, and a smooth conversion. The staff quickly learned how easy it is to operate, and we all appreciate the greater control. MED990 is a big success."

Benefits keep adding up.

"We'd planned carefully, and we knew what kind of benefits to expect: Better control over accounts receivable. Faster data entry. Reduced follow-up time.

"Then, after installation, we found we could save even more time in registration. Working with Poorman-Douglas and the MED990, you continue to discover labor-saving opportunities. That's exciting!"

Is MED990 the business partner you need?

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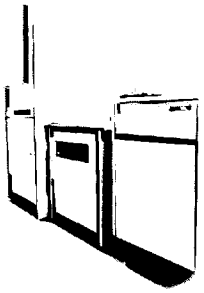
Get the Doctor's Guide.

Send for your copy of the Poorman-Douglas *Doctor's Guide to In-House Computers*. Better yet, call for a convenient, no-obligation consultation in your office.



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The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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SOCIETY NEWS BRIEFS

Nonprofit Counseling Service Available for Patients

Consumer Credit Counseling Service of Tacoma is a nonprofit agency offering counseling, advice and debt management services to individuals and families threatened by bankruptcy. The service reports it has helped more than 4,200 families pay off more than $11,000,000 in debts, including approximately $300,000 to physicians since its founding in 1970.

The service asks physicians to refer patients or others who need financial assistance and management to the Tacoma CCCS office. Additional information is available by calling Consumer Credit Counseling of Tacoma, 588-1858.

Volunteer Physician Needed

Fire District No. 10 (Fife/Milton) is seeking to establish an ALS (advanced life support) defibrillator program. State regulations require that an ALS provider must have a supervising physician. Physicians interested in assisting Fire District No. 10 are urged to contact Chief Miller, 922-8424.

The job of supervising physician entails monthly meetings with personnel, completion of minimum reporting requirements, and membership on the Medical Society's Emergency Medical Standards Committee. For additional information, contact Mr. David Vance, EMS Division Administrator, Tacoma-Pierce County Health Department, 593-4530.

Physicians Elected to Membership

The following physicians were elected to membership in the Medical Society of Pierce County at the January 10 Board of Trustees meeting:

Drs. James D. Fitz
Richard B. Lyman
Cynthia Wilson
John R. Van Buskirk
Robert L. Huck
Bret M. Rath
Stanley Jackson
Kevin C. Elliot
Valencia-Adams Elliott
Douglas M. Blumenthal
David E. Law

School Forms Available From Society Office

Physicians are reminded that *School Health Report* and *Dispensing of Medications at School* forms are available by calling the Medical Society office, 572-3667. A "clean" copy will be sent to the physician's office for reproduction. The forms have proven very useful for physcians in the school community in Pierce county in recent years. The forms have been approved by the Medical Society's Public Health/School Health Committee.

Cover Photo: Congratulations on a job well done! Incoming President Pat Duffy (left) presents Bob Lane with a plaque of appreciation for his many efforts as MSPC president in 1983. Duffy was later inaugurated as the 91st president of the Medical Society of Pierce County.

President's Page

A WARM WELCOME

A warm welcome to all of you and best wishes for a prosperous New Year from your new president. I have accepted this position with a certain amount of humility and trepidation for what the future may hold for the practice of medicine.

There are a few things this monthly column won't be: It will not be brilliant and "computerized" like the commentaries of the late Dr. Charles Reberger; it will not be bilingual like the remarks of past president Dr. George Tanbara; it will not reflect the "insider" perspective apparent in the columns from Drs. Elmer and Lane. It will be basic, homespun and, hopefully, keep all of you abreast of the thinking and hopes of the Board of Trustees and me.

It has been extremely difficult to say good-bye to our old Executive Director Mr. Thomas Curry. He has left a void which will be difficult to fill and a working knowledge of the Society that has not been surpassed in my 33 years as a member. I personally want to welcome aboard Mr. Douglas Jackman, our new Executive Director. After a review of some 90 applications and seven personal interviews by the Executive Committee and other members of the Board, he was selected to replace Mr. Curry. He brings to your Medical Society an impressive background in medical administration. We both ask that you give us time to learn, as we continue on with the business of our Society.

Our last president, Dr. Robert Lane, other board members and I outlined a two-year plan at our goal-setting retreat early in 1983. We prioritized 10 goals in which we were particularly interested and will continue to work on during 1984. I am glad to report that progress already has been made in many of our priority areas. However, there is much more to be done. These items have been listed previously in the Bulletin and are available on request at the Society office.

There are many activities which will require new faces and new input to make progress in our Society's many functions. I will be asking many of you to serve on committees. I know how busy all of us are, but I hope you will accept and do your best.

I encourage all of you not only to join and support the Medical Society of Pierce County and the Washington State Medical Association, but also the American Medical Association. I extend to the spouses an invitation to join the Medical Auxiliary, which has become a very valuable arm in our Society.

Again, I would like to thank you for electing me president of our organization. I will do my best to guide us in the right direction in this medical revolution of which we are a part.

–JPD

Better Hearing is Our Business

Among those who experience hearing impairment in both ears, more than 50 percent are over 65 years of age. It is not surprising if elderly hearing-impaired persons are among your patients.

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Western Clinic, a partnership of multi-specialty physicians, is recruiting a Family Practice physician with an established practice for its Tacoma office. If the characteristics of a group practice sound good to you, call Ted Crowell, MD or Don Reddington, Executive Director, for additional details. All inquiries will be strictly confidential.

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Educational Clinics Incorporated

EDUCATIONAL PROGRAM FOR SCHOOL DROPOUTS

Educational Clinics Inc., a recently established local program for school dropouts, made a presentation late in 1983 to the Medical Society's Public Health/ School Health Committee. The committee offered ECI an opportunity to present its story to the medical community through the pages of the Bulletin. ECI's presentation follows.

–the editor

Educational Clinics Incorporated (ECI) developed the concept of the educational clinic for school dropouts. The ECI program prepares students 13 through 19 years of age to either re-enter a regular school program or take the GED (high school equivalency) test and go on to work or receive further training.

Much like a medical clinic, ECI treats its students' educational problems through individual diagnosis, prescription of an individualized course of study and evaluation and follow-up. ECI was established in Everett in 1974 and has worked with over 2,500 young people. In October 1982, ECI opened its Tacoma clinic at 707 Pacific Avenue.

ECI's students are a "high-risk" group. Dropouts have a higher unemployment rate than high school graduates and are more likely to be incarcerated or dependent on welfare programs. Washington State's AFDC (welfare) programs, half of whose recipients are dropouts, cost taxpayers $225 million per year. Our correctional institutions, 70 percent of whose inmates are dropouts, cost $144 million per year. ECI's early intervention gives clinic students a second chance at succeeding in the educational, social and economic mainstream while offering long-term tax savings to the community.

The clinic program combines instruction in the basic academic skills with employment orientation, school re-entry orientation, personal counseling and motivational development. The program is individualized to fit each student's learning capacities and goals. Diagnostic tests are used to place every student at the appropriate skill level. With classes grouped by ability rather than by age, ECI students can work at their own skill level and be successful immediately. Students move to more advanced ability groups as their skills improve.

ECI's instructors teach more than the basic skills. They help students understand and deal with personal and family problems. Student-teacher relationships are positive and supportive, based on caring and mutual respect. Staff are chosen for their ability to inspire trust and achievement in reluctant students, as well as for their teaching skills. All teachers and clinic administrators are state certified.

Classes are small and well disciplined. The values of courtesy, honesty and personal responsibility, rather than detailed rules of conduct, are emphasized for both teachers and students.

ECI's clinic program is a private sector educational solution to a social problem that effects the entire community. ECI combines the traditional goal of the best education possible for all Americans with the incentives and flexibility of the free enterprise system.

ECI's product is the measured improvement of students' academic skills and motivation to enter constructive activities in society. Unlike most traditional educational programs, ECI emphasizes results rather than process. Teachers and managers are held accountable for the results the program produces.

The goal is to provide ECI's product in the most cost effective manner possible. The average cost per student is only $1,100. The average clinic student gains 1.3 grade levels in about 14 weeks at ECI. About 70 percent of all students leave the program in a positive way, either passing the GED or pursuing further training, education or employment. About two-thirds are engaged in constructive activities such as work, school, training or military service at the time of a follow-up contact six months after leaving ECI.

The clinic program is accountable. Its fee-for-service billing system charges only for hours students are actually in class and receiving instruction. The program is subject to regular legislative and financial audits. A computerized student data base allows detailed evaluation and reporting on any group of students.

The success of ECI's program led the Washington State Legislature to pass enabling legislation in 1977 that authorized

continued on page 8

Educational Clinics Incorporated,
continued from page 7

the state to certify and fund educational clinics. Unfortunately, because state funding has been inadequate to keep up with student demand for enrollment in the program, ECI and the eight other organizations that have been certified as clinics on the ECI model are able to serve only about one to one-half percent of the state's eligible dropouts.

ECI continues to actively work to develop legislative support for increased appropriations to the clinic program. As an interim measure, until sufficient state funding is available, ECI has developed procedures through which the private sector can provide tuition funding for these hard to reach young people. Contributions are made to a non-profit community foundation, such as the Greater Tacoma Community Foundation, which administers the funds through procedures that provide necessary fiscal and administrative controls.

ECI requests the support of the medical community. Support can take a variety of forms: Referring students to the program; increasing community awareness of the clinic; urging legislators to increase appropriations to educational clinics; or, donating tuition grants. Interested physicians are encouraged to visit ECI to observe the program and meet its students and staff. For further information or to schedule a clinic visit, contact Ann Fera, ECI Area Manager, 627-6513.

Ann Fera, ECI
Area Manager

Progress Notes
A Report from Membership Benefits

CURING THE "TURNOVER BLUES"

Last week while attending an open house at a new medical office building, I overheard one physician remark to another, "I would rather do a swan dive off the Narrows Bridge than go through hiring staff again." Why is employing personnel greeted with such glee throughout the working world?

Simply stated, it is a pain (usually located on the posterior side of the body). Actually, this statement deserves elaboration; it is a pain with a cure. Unfortunately, most victims blighted with the turnover blues stop their medication half way through the course of treatment and end up with a relapse that is often worse than the initial problem. Undoubtedly you would like to avoid this and seek a proven treatment plan which guarantees lasting relief. Time is the answer.

Take Time To Prepare A Prevention Plan

You need to prepare:

- Position requirements.
- Interview questions.
- Answers to the questions.
- Tests, where possible.
- A uniform method of recording responses.
- Proper orientation, include training time.

Before you need to hire an employee, prepare as much as possible. Job descriptions are the first step in preparation. They list the minimum general skills and abilities required as well as particulars. Job descriptions outline functions and duties for prospective employees and help the employer achieve the second step, developing the interview questions.

These questions are best left open-ended; that is, a question one can not answer with a simple yes or no. For example, a good open-ended question for a prospective office manager is, "What would you do if we had a snowfall and half the office staff failed to show up?"

Open-ended questions are critical when seeking responses to issues that involve ethics. For example, "How would you, as my office nurse, handle phone calls when advice is sought?" You should have different answers for each question which range from excellent to unacceptable; this is the third part of the preparation.

Besides preparing questions and answers, develop other systematic approaches to screening persons, such as tests. You can have your potential medical office assistant, who would do urinalysis on the job, look at a recent slide under the microscope and interpret. Sit transcribers down with a tape and typewriter. Time them. People tell you what you want to hear in an interview. Having applicants show you they can do what they say is a very good way of encouraging honesty.

An important step in preparation, often overlooked, is developing a selection grid when you are recording results. Make your grid comprehensive. It needs to reflect the criteria you are screening for, including attitudes. Develop a uniform method of recording responses, and a scoring system. Keep in mind the method you create is not as critical as your consistency in judging all persons by the same set of standards.

Finally, be prepared when you select an employee to allow for proper orientation and training. This will insure that the new employee does not quit in frustration because too much was expected too soon. You always have the option of hiring temporary help if the work load is too great. Remember, it is less expensive to buy time with temporary help than to rush into selecting the wrong person and later suffer the consequences of repeated turnover.

In conclusion, do not fall victim to the rising epidemic "the turnover blues." Take time to prepare. It helps you select systematically. Applicants receive the same treatment and are judged accordingly, which brings objectivity into what can be a highly subjective process. Preparation allows you to select rather than reject, and that can make all the difference in the world.

Consider the following statement from the AMA Practice Management Division: "The cost of recruiting, hiring and training a new employee, considering the non-productive time for both the trainer and the trainee, is $5,000.00." At this cost, the old adage "an ounce of prevention is worth a pound of cure" certainly makes sense.

For help in meeting your office staffing needs call your Medical Society's Placement Service, a division of Membership Benefits, Inc. We are anxious to assist.

Linda Carras, Director
Membership Benefits, Inc.

FESTIVE HOLIDAY DINNER HONORS OLD, NEW OFFICERS AND TRUSTEES

Newly elected Medical Society officers and trustees were installed at the annual joint Medical Society-Auxiliary dinner in December. Two hundred forty eight physicians and spouses attended the festive affair held at the Tacoma Dome Convention Center. The evening also was highlighted by the recognition of Dr. Stan Tuell by the Medical Auxiliary for his many contributions to medicine and the community, and a fund raising raffle for the Auxiliary's Student Recognition Award Program.

Outgoing MSPC President Dr. Robert E. Lane chaired the meeting. He expressed his thanks to "excellent committee chairmen and Board members for their involvement." Incoming President Dr. Pat Duffy presented a plaque to Dr. Lane for a "job very well done." Said Duffy, "Yours will be a hard act to follow."

Duffy paraphrased John Kennedy's 1960 inaugural speech when he said, "ask not what your Society can do for you, but what you can do for your Society." The 1984 MSPC president noted the many changes taking place in the medical practice environment and expressed his conviction that, more then ever, medicine must be pro-active and address head-on the challenges it faces.

Outgoing trustee Gordon R. Klatt (right) was among the officers and trustees thanked by Bob Lane for their service in 1983. Dr. Klatt served a two year term on the Medical Society's Board.

During the pre-dinner festivities, Art Popham, producer and host of PM Tacoma, a local, nightly radio show, interviewed a variety of people. Here, MSPC President Bob Lane (left) discusses Medical Society activities in the community with Popham.

Student Recognition Award raffle tickets were enthusiastically purchased during the cocktail hour. Sharon Lawson, Auxiliary president-elect, was one of the several volunteers making the tickets available to physicians. Dale Hirz (center) and Charles LeR. Anderson (right) were among those who purchased raffle tickets.

In announcing the results of the election of 1984 officers and trustees, Dr. Lane said, "all candidates were excellent representatives of the local medical community. The votes were very close down the line. It is frustrating that not everybody could be elected."

1984 officers are: Drs. Guus W. C. Bischoff, president-elect; Richard S. Hawkins, vice president; and, Henry F. Retailliau, secretary-treasurer. Newly elected trustees are: Drs. Richard G. Bowe, C. Stevens Hammer, John H. McGowen and Myra S. Vozenilek.

Dr. Lane presented plaques of appreciation to outgoing trustees and officers for their service on behalf of the Medical Society and community during 1983. Plaques were awarded to Drs. Richard S. Hawkins, vice president; Juan F. Cordova, secretary-treasurer; and, Robert F. Kapela, Gordon R. Klatt, Gilbert J. Roller and Bruce D. Buchanan, trustees.

Funds were raised for the Auxiliary's Student Recognition Award Program through a special raffle conducted prior to the dinner. Dr. Guus Bischoff, Tacoma, the 1984 president-elect, won a case of wine donated by the Medical Society's Board of Trustees. Dr. Kenton Bodily won a set of woven placemats. The raffle raised $408.00 for the program.

Early in the program, Dr. Lane paid special thanks to members of the Auxiliary who assisted in the preparation for the evening–Gloria Virak, Dorothy Truckey, Sharon Lawson, Lavonne Campbell, Debbie McAlexander, Cindy Anderson, Sonja Hawkins and Nikki (and Jim) Crowley.

In presenting the Auxiliary's "Award of the Apron" to Dr. Tuell, Gloria Virak, Auxiliary president, noted his many contributions and outstanding service to the community.

Dr. Duffy introduced and welcomed Mr. Douglas Jackman as the new executive director of the Medical Society. Mr. Jackman comes to the Society from the Puget Sound/Southwest Region of the Washington Lung Association. Mr. Jackman assumed the office of executive director effective January 16.

The evening concluded with a talk on "Aesculapius Beseiged–Medicine in a Changing World" by Dr. Charles W. Bodemer, professor and chairman of biomedical history at the University of Washington.

1984
MEDICAL SOCIETY OFFICERS
AND TRUSTEES

President	*James P. (Pat) Duffy, MD*
President-elect	*Guus W. C. Bischoff, MD*
Vice President	*Richard Hawkins, MD*
Secretary-Treasurer	*Henry F. Retailliau, MD*
Trustees	*Richard G. Bowe, MD (1984)*
	Richard E. Gilbert (1984)
	Gregory A. Popich, MD (1984)
	Alan D. Tice, MD (1984)
	C. Stevens Hammer, MD (1985)
	John H. McGowen, MD (1985)
	Myra S. Vozenilek, MD (1985)
	Gloria Virak

Stan Tuell received the Auxiliary's "Award of the Apron." Auxiliary President Gloria Virak noted his many contributions to the community before presenting him with his "volunteer apron."

Guus W. C. Bischoff, announced earlier in the evening as the 1984 president-elect of the Medical Society, also won the case of assorted wines as part of the raffle to raise funds for the Student Recognition Program.

The dinner was preceded by a cocktail hour at the Tacoma Dome Convention Center. Jo Roller, (left) and Kathy Miskovsky shared a lighthearted moment with George Delyanis.

State Seeking Review Positions in Olympia

The Washington Office of Disability Insurance is seeking physicians to review the medical evidence and disability claims under the Social Security and Supplemental Security Income programs. Physicians are asked to commit a minimum of 20 hours per week at our office in Olympia.

Orientation to the Disability Program and office space will be provided.

Interested physicians are asked to contact:
Eleanor E. Giffin, M.D., Chief Medical Consultant, or
John E. Peters, Professional Relations Manager,
Office of Disability Insurance.

They can be contacted on a toll free line, **1-800-562-6074,** or at the following address:
Office of Disability Insurance
P.O. Box 9303
Olympia, WA 98504

THANKS FOR A GREAT JOB DEPARTMENT

1984: A time of new beginnings, renewed commitments, and old resolutions dragged from the closet again. Here's to you, George Orwell, 1984 *did* arrive, just as you said it would, but the PCMA continues to do quite well, thank you!

Thanks for A Great Job Department

To *Carol Annest* and her committee for providing us with another joyous holiday party.

To Santa *Tom Miskovsky* who filled our children's eyes with stars at the holiday party.

To magician *Harry Lawson* who delighted and entertained our children with his bag of tricks at the holiday party.

Hats off to you, *Trudy Klatt*, and your committee for planning a very special Joint Holiday Dinner with our husbands. The Student Recognition Award Fund received $408.00 from the sale of raffle tickets during the evening. *Dr. Kenton Bodily* won a set of placemats and *Dr. Guus Bischoff* won a case of wine. And, for outstanding volunteer efforts, *Dr. Stanley Tuell* was presented the Order of the Apron Award.

To *Pat Knight*, AMA-ERF chairman, for representing the PCMA with a warm and lovely holiday card. We all know how much time and energy is necessary for this project and we appreciate her efforts. Proceeds from this project totalled approximately $13,850.00. Our thanks to the following additional contributors: *Marion Vimont, Mary* and *Marty Schaeferle, Tom* and *Sandy Irish, Stan* and *Karen Bloustine.*

1984-85 Officers

The following slate of officers for 1984-85 has been approved by the Board to be presented to the general membership for a vote of approval:

President-elect	*Virginia Miller*
1st Vice President (Programs)	*Norma Lloyd*
2nd Vice President (Membership)	*Marilyn Bodily*
3rd Vice President (Bylaws)	*Rubye Ward*
4th Vice President (Arrangements)	*Phyllis Pierce*
Corresponding Secretary	*Betty Virtue*
Treasurer	*Dotty Truckey*
Dues Treasurer	*Shirley Murphy*

To all those ladies who opened their homes for the Special Interest Group coffees in December. Once again, the membership showed great enthusiasm and support for our programs.

Looking Ahead

Watch for more information on the Health Fair to be held at the Tacoma Mall on President's Day. Chairman Sally Larson will be seeking husband and wife volunteers to perform blood pressure checks.

Friday, February 17, 1984, will be the date of the next PCMA luncheon meeting to be held at the home of Mrs. Christopher Miller. Dr. Lane Berber, Seattle psychologist and author, will discuss his research on stress in medical families.

The PCMA would like to extend a warm welcome to Mr. Douglas Jackman, new executive director of the Medical Society of Pierce County.

One final note: Big Brother knows you haven't sent your dues of $38.50 to Shirley Murphy!

–Janet Fry

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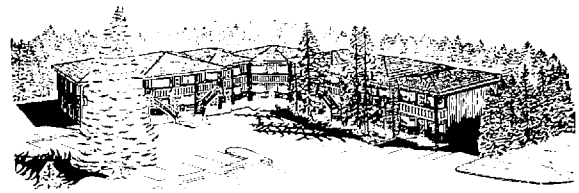

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Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Robert U. Finnerty, MD, *Urology.* Born in Montclair, NJ, 5/24/50; Georgetown University School of Medicine, 5/76; internship, Walter Reed Army Medical Center, Washington, D.C., 7/76-6/77; residency, Madigan Army Medical Center, Tacoma, 7/77-6/81; Washington State License, 1983. Dr. Finnerty is currently practicing at Physicians Medical Center, Tacoma.

Betsy L. Fine, MD, *Family Practice.* Born in Baltimore, MD, 9/7/53. George Washington University School of Medicine, Washington, D.C., 1980; internship, Swedish Hospital, Seattle, 7/80-6/81; residency, Swedish Hospital, 7/81-6/83. Washington State License, 1983. Dr. Fine is currently practicing at the Sumner Clinic, Sumner.

Dennis D. Drouillard, MD, *Ophthalmology.* Born in Oklahoma City, OK, 12/19/52; Pennsylvania State University, Hershey Medical Center, 1979; internship, Hershey Medical Center, 1979-6/80; residency, Eye and Ear Hospital, University of Pittsburgh, 6/80-6/83. Washington State License, 1983. Dr. Drouillard is practicing at Allenmore Medical Center, Tacoma.

Classified

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Space for Lease – 1,550 square feet in Medical-Dental complex. Dental or medical specialist wanted. Excellent exposure. Lakewood. Call Dr. Kenneth Ring (206) 584-6200.

Portable Tektronic EMG machine & accessories, print-out attachment & computer ability. 1-1/2 years old. $8,000 and/or terms. 627-7177.

Tacoma and Seattle Practices – CHEC medical Centers have practice opportunities for physicians interested in primary medicine/minor emergency care. Guaranteed base plus financial incentives, mal-practice coverage, health insurance, paid vacation and CME time, and practice equity provided. Please send C.V. to Richard Miller, Director of Physician Services, CHEC Medical Centers, 2200 6th Ave., Suite 1200-H, Seattle, WA 98121

GP Retiring – Walk in and take over. Reasonable terms. Beautiful Mt. Vernon, 3 blocks from hospital. 428-2626, day or night.

For Lease – Quad Professional Building, 1st Ave. S. and S.W. 330th, Federal Way, WA. New 3-story building for Medical/Dental professionals, ready for your tenant improvements. Ownership available through lease terms. Call today for more information. Mike Miller, 244-5706 or 284-7343 (evenings). Portal West Realty.

Medical Building for Sale – Gig Harbor, WA, Suburb of Tacoma. Quality living. Excellent downtown location. 2,885 sq.ft., includes 4 exam rooms, surgery, lab & x-rays. Commercial zoning. $265,000 on attractive terms. Equipment also available. Contact Wm. L. Hess, 3101 Judson St., Gig Harbor, WA 98335, (206) 858-6141.

For Rent – Basement medical office in Tacoma Medical Center, corner of South 12th and L. $125 per month. 572-8876 or 272-1788.

Forced to Sell – Lake Steilacoom building site, 97 ft. waterfront by 477 ft. deep. Listed at $195,000, but all offers will be considered. Charmaine Island, Parkwood Realty Corporation, 581-4040 or 584-4694.

COLLEGE OF MEDICAL EDUCATION

AH = Allied Health Personnel
P = Physician

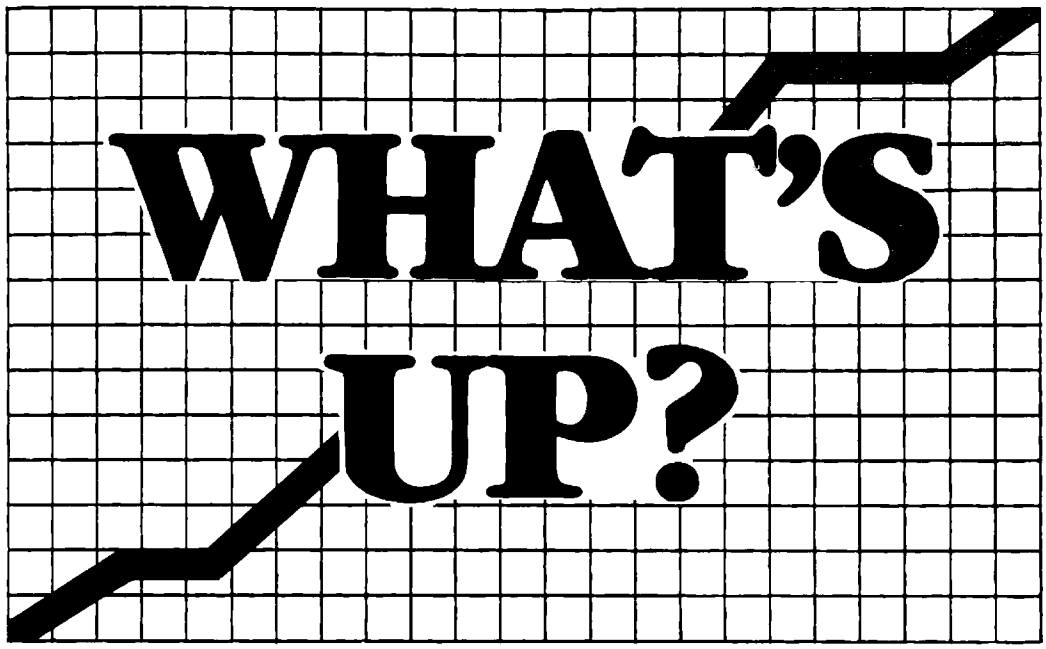
Continuing Education Programs for January-July, 1984

(Programming is subject to change–individual notices will be sent preceding each program)

Date	Course/Topic	Coordinator(s)
January		
26	**Endocrinology (P)**	K. D. McCowen, MD
27	**Nursing Leadership and Image (AH)**	L. Pelham, RPh
February		
10/11	**Central Supply (Portland) (AH)**	C. Duane
1/8/15	**Moral Ethical Issues In Health Care (P) (AH)**	D. Bader, MD
16/17/23/24	**Acute Medicine (P)**	T. Apa, MD
	Discharge Planning (AH)	C. Johnson, RN
	The Ward Secretary (AH)	D. Absher, RN
23	**The Neonate (P)**	J. Sakakini, MD
March		
2	**Urological Nursing**	M. Ramsdell, RN
9/10	**Critical Care Conference (P) (AH)**	B. Rubin, RN/B. Weled, MD
	Image (AP)	K. Jordan, RD
	Central Supply (Vancouver, B.C.) (AH)	C. Duane
April		
5/6	**Tacoma Academy of Internal Medicine (P)**	H. Retailliau, MD
13/14	**Pediatric Advanced Life Support (AH)**	R. Scherz, MD
14	**Endoscopy (Auburn) (P)**	R. Johnston, MD
27/28	**Tacoma Surgical Club (P)**	W. Martin, MD
28	**Days of Pediatrics (P) (AH)**	R. Scherz, MD
May		
4	**Neurology for the Non-Neurologist (P)(AH)**	J. Griffith, MD
9/10	**Cardiology (P) (AH)**	G. Strait, MD
June		
7	**Nutritional Support (P) (AH)**	L. Pelham, R.Ph.
July		
	Budget (AH)	

Dates are subject to change-Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137



If you've looked at your practice expenses lately, you know what's up ... the cost of professional liability insurance!

Unless of course you're covered by Physicians Insurance. We're proud to announce we're holding the line on rates for 1984. That's right. *No* increase for 1984.

How can we do it?

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Now that you know what's up and what isn't, shouldn't you call Physicians Insurance?

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Exchange & Association

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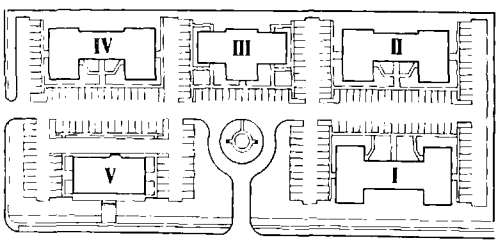
Where the People Are. Where the Growth Is.

Everyone knows the positive impact a superb office location has on the practices of professionals. But today there is a need for more than high visibility and easy access. Patients and clients seem to prefer a warm, relaxed, comfortable environment. Capitol Square offers an almost home-like atmosphere with parking virtually at the front door.

That is why the practices of Capitol Square professionals have grown so fast. Here is a convenient colonial village that extends a warm visual invitation to occupants of the almost 30,000 vehicles that pass by daily.

You can lease or buy all or part of a building at Capitol Square and custom design your own space. If you're planning to build, all the time consuming problems have already been solved. No searching for suitable, properly zoned land. No long, drawn out dealings with building departments, architects and contractors. And, having worked with professionals before, we understand all of the unique building requirements.



The master plan for Capitol Square is for five buildings. Building I is finished and fully occupied. Building II will be ready in early 1984.

YOU'LL BE LOCATED IN THE PATH OF DRAMATIC GROWTH. Federal Way is recognized as one of the fastest growing communities in the state. The prediction is for a population of 101,011 by 1990.

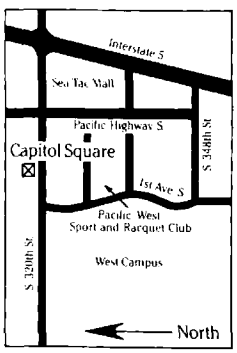
A growing number of nationally known businesses have located in nearby West Campus, including Dow Jones, Inc., publishers and printers of the Wall Street Journal. Zoned for multiple and single family housing, businesses, offices and light industry, development is now 55 percent complete. By 1984, 5,000 to 6,000 persons will be employed within the predominantly professional labor force. It is, without question, an ideal location for additional professional services.

For complete details and a tour of the facilities, contact:

Ms. Dorla D. Allred
On site office: 941-7809 (Seattle), 927-8104 (Tacoma).
Residence: 643-3728.

John L. Scott, Inc.
Exclusive leasing and sales agent; broker inquiries invited.

DRIVING DIRECTIONS: From I-5, take the 320th Street exit and proceed west past the Sea-Tac Mall across Pacific Highway South, less than one mile to Capitol Square which will be on your right.



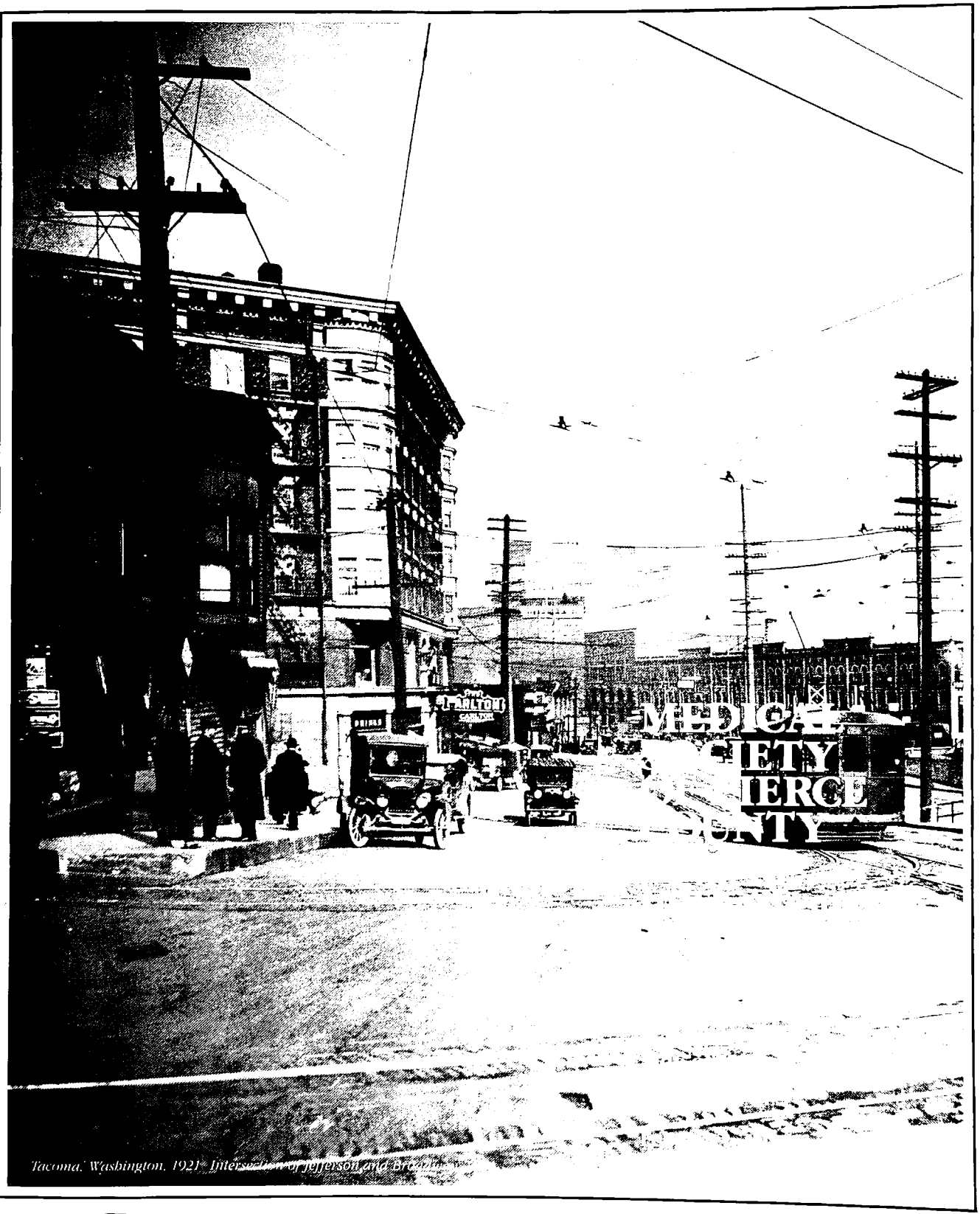
Lease or Buy

CAPITOL SQUARE

720-728 South 320th
Federal Way, WA 98003

Medical and Professional Business Park

The Bulletin



Tacoma, Washington, 1921. Intersection of Jefferson and Broadway.

How Poorman-Douglas can help you cure occluded cash flow.

For two decades, Poorman-Douglas has been helping good doctors become good businessmen.

The automated medical accounting systems we offer can let you check on the financial health of your practice as closely as you look after the physical health of your patients. Just as they have for some 1,600 physicians throughout the Northwest.

What's more, Poorman-Douglas is the only Northwest company to offer all three categories of automated medical accounting products. So we're singularly qualified to prescribe, objectively, the appropriate system for your practice.

Option #1: Service Center Processing.

You get the benefit of computerized billing, insurance claims and patient records, with no outlay for equipment. All data is processed by Poorman-Douglas at our nearest service center. We'll mail reports, bills or insurance forms promptly, professionally and worry-free, and you get [illegible] on receivables or for production.

For many practices, full-service processing remains the best, most economical system.

Option #2: The In-House Computer.

Large or high-volume practices often need their own computer. The Poorman-Douglas MED 990 is the best we've seen; we designed it to be. The MED 990 combines cost-effectiveness with a powerful set of features aimed directly for medical offices. A complete interactive medical information system, it can smooth scheduling and billing, improve cash flow and upgrade patient records, while helping maintain internal control.

Option #3: On-Line Processing.

The third option for automating your record-keeping is on-line processing, our newest product. Your Poorman-Douglas terminal gives you a window for entering data and inquiring about patient accounts. Add an optional printer and produce account printouts on demand in your own office, or let Poorman-Douglas handle it all for you. Either way, you have quick access to a powerful medical information system without the investment of owning one.

One of these Poorman-Douglas systems is the business partner your practice needs. The first step toward choosing among them is to send for our brochure. Better yet, call for a convenient, no-obligation consultation by a Poorman-Douglas specialist.

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Seattle 270 W. Harrison (206) 283-9781
Portland 1325 S.W. Custer (503) 245-5555
Boise 7[illegible] (503) 666-1871

☐ Please send me more information on your medical accounting systems.
☐ Please contact me for a consultation at my office.

Name _____

Address _____

City _____ State ____ Zip _____

Phone (____) _____

Mail to: Poorman-Douglas Corporation
1325 S.W. Custer Dr.
Portland, Oregon 97219

The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

Published Monthly by the Medical Society of Pierce County, 705 South 9th, Suite 203, Tacoma, WA 98405. Telephone (206) 572-3666. Bulk Rate U.S. Postage paid at Tacoma, Washington. *The Bulletin* is published in the interest of medicine and allied professions. The opinions herein are those of the individual contributor and do not necessarily reflect the official position of the Society unless so stated. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. *The Bulletin* and the Medical Society of Pierce County reserve the right to reject any advertising. Advertising rates may be secured from Val Dumond, Advertising Resources, 2607 Bridgeport Way W., Tacoma, WA 98466, (206) 564-7882. *The Bulletin* is printed in Tacoma, Washington by Lakewood Printing.

February, 1984

Summary of Medical Society and Local Community News

SOCIETY NEWS BRIEFS

Critical Care Program Notes Opening of New Special Care Facility at Tacoma General Hospital

A special two day critical care program will be conducted March 9 and 10, 1984, at Tacoma General Hospital.

The conference is intended to teach participants to recognize present and future trends impacting the organization and delivery of modern critical care. Up to fifteen hours Category I credit will be awarded. On both days the program begins with morning sessions followed by hosted lunches and afternoon breakout sessions. Program participants may select sessions specifically related to their areas of interest.

Registration for physicians is $150. This includes a continental breakfast, the hosted lunches, and a syllabus for the course. Pre-registration is required before March 2. For additional information, contact the College of Medical Education, 627-7137. *See page 12 of the Bulletin for Registration Form.*

Pictorial Directories Available

The 1984 Medical Society of Pierce County Pictorial Directory has been received in the Medical Society office. Directory orders are being filled as expeditiously as possible.

If physicians desire additional copies beyond the number ordered (and the one free copy provided to each physician photographed in the directory), please call the Medical Society's MBI office, 572-3709. A limited supply is available for purchase.

1984 Committee Chairmen Appointed

The following members will serve as chairmen of Medical Society committees in 1984:

Budget/Finance . . . *Henry Retailliau (Internal Medicine)*
Credentials . . . *Ronald G. Taylor (Surgery)*
Emergency Medical Standards . . . *Mark E. Jergens (EM)*
Ethics/Standards of Practice . . . *Gilbert J. Roller (Radiology)*
Grievance . . . *Robert E. Lane (Internal Medicine)*
Interprofessional . . . *Herman S. Judd (General Practice)*
Jail Health Advisory Board . . . *Michael W. Priebe (Gastroenterology)*
Legislative . . . *James D. Krueger (Internal Medicine)*
Medical Library . . . *Juan F. Cordova (Pathology)*
Continuing Medical Education . . . *David M. Brown (Family Practice)*
Medical-Legal . . . *Marcel Malden (Neurology)*
Professional Relations . . . *William A. McPhee (General Practice)*
Program . . . *Richard S. Hawkins (Family Practice)*
Public Health/School Health . . . *Terry Torgerud (Pediatrics)*
Senior Citizens . . . *Thomas Clark (Consultant, Public Health)*
UTH Quality Assurance . . . *David Sparling (Pediatrics)*

Medical Society of Pierce County Leads in County Representation at Washington State Medical Association Leadership Conference

The Medical Society of Pierce County once again was a leader in county representation at the Washington State Medical Association Leadership Conference and Legislative Workshop held in Olympia, January 18-21.

Many members took advantage of the Legislative Reception to meet and discuss with their personal legislators some of the issues facing the medical community today.

Some of the Medical Society of Pierce County members attending were: President James Duffy and President-elect Guus Bischoff, leading the large contingent, along with Drs. Keith Demirjian, Richard Gilbert, Richard Hoffmeister, David Hopkins, Dudley Houtz, Richard Hawkins, Ralph Johnson, James Krueger, William Marsh, Robert Scherz, James Symonds, Stanley Tuell, and Myra Vozenilek.

Auxiliary members attending were: Cindy Anderson, Sonya Hawkins, Sharon Lawson and Gloria Virak.

A summary of the program could be that the medical community must become aware of the trends taking place in the delivery of care today, and the membership must become actively involved in helping to arrive at the decisions affecting the delivery of care.

Tacoma-Washington Physicians for Social Responsibility Holds Membership Meeting

Tacoma-Washington Physicians for Social Responsibility Pierce County held their monthly general membership meeting January , 1984 in Jackson Hall. The group addressed the tasks of educating physicians and other health professionals to the dangers of the current nuclear arms buildup. Aims for this election year are to educate

continued on page 17

President's Page

Goals for 1984

Since last month's Bulletin raised the question of our goal-setting for the 1983-84 year, there have been questions raised as to goals implementation and, in fact, the content of some of them. Following are the 10 goals which have been set forth:

1) Establish the Medical Society of Pierce County as the spokesman and leader for all segments of medicine in Pierce County; take definitive stands on local issues, including environmental health issues.

2) Educate physicians and give them the tools to compete in the new, competitive areas, to help them become more politically and socio-economically astute.

3) Establish a strong public relations program and identify public needs, address them, communicate to the public the good things medicine has done; participate in consumer education and serve as advocate for the consumer's health needs.

4) Establish and maintain high standards of ethics and professionalism in medical care in Pierce County to protect the patient.

5) Help shape the future of medical care delivery system in Pierce County. Define what is best for Pierce County residents, outline options, education and help implement them.

6) Define tangible reasons to belong to the Medical Society. Offer benefits and services to physicians that help them build ethical and successful practices to build a strong membership base.

7) Enhance relations and cooperation between physicians and hospitals, their administrations and boards, and between physicians and hospital medical staffs. Build bridges to assist in delivery of quality, appropriate medical services to the community.

8) Directly support quality medical care through the operations of the College of Medical Education and the Pierce County Library.

9) Devise a community-wide referral service to assist people in receiving medical care from physicians without regard to their ability to pay for such services.

10) Build further cooperation between local, county medical specialty societies.

As you can see, many of these goals are an ongoing process. Strategy and plans for their accomplishment have been effectively worked out by your Board of Directors, and are available at the Medical Society office.

Several of these goals merit additional comment: Goal 1 is pretty much self-explanatory, and we have made considerable progress in accomplishing it. However, the area of senior citizens–and what specifically our Society can do for them–has been lagging behind. I hope to encourage development of an active committee to aid this fast-growing segment of our population.

Goal 2–Last year's general membership meetings were devoted almost entirely to this issue. I know there still must be considerable discussion of the ways it may be accomplished. Specifically, a "survival kit for the 80s" must be developed.

Goal 6 needs little explanation, other than to say please don't have the "gunbarrel" vision of letting someone else do everything. A strong membership base, combined with a strong voice in the future of medicine, is a vital element in our continued success.

Goal 7 merits special attention, in that Pierce County has been designated as a pilot project for a cooperative venture between physicians and hospital medical and administrative staffs. A steering committee has just been appointed, and is drafting several ideas on how to implement this goal–a goal critical to continued health care delivery, and cooperation among the above-mentioned constituencies.

Goal 9–Our community-wide referral service continues to be a valuable asset, and an active part of our Society's office obligations. Daily calls are received from many citizens who seek not only physicians, but access to some medical care with limited resources.

We have taken on a major task in our efforts to accomplish these goals. However, one must set the standards high and keep a proper focus on the importance of our efforts to providing quality medical care to our community.

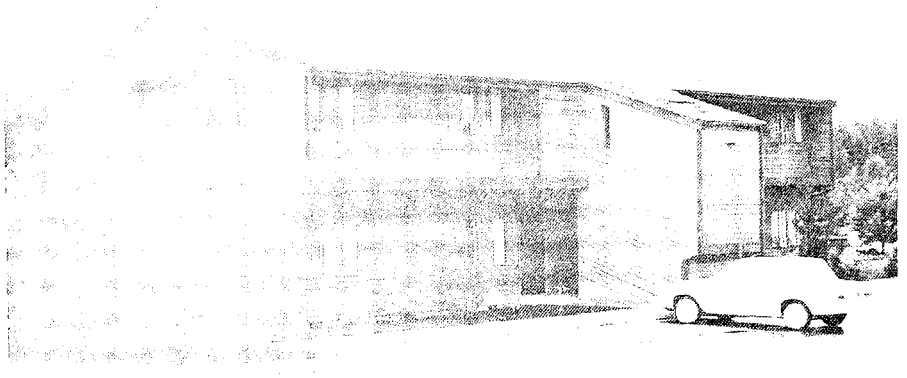
I would like to thank the many physicians who have volunteered their services to me and the Society, without any strings attached or any individual benefits accrued. In the past month, many committee and ad hoc assignments have been made. To those of you who have been reluctant or slow to respond, I assure you that your expertise is needed and would be greatly appreciated by the Medical Society of Pierce County.

-JPD

Professional Office Space For Sale

TAX SHELTER INVESTMENT

(NOT A LIMITED PARTNERSHIP)



Seller will guarantee break even cash flow for two years. For a 50% bracket investor, the investment will yield a minimum 38% return on invested capital over two years. A two year return of 59% is possible.

Minimum investment: $73,000
Maximum investment: $365,000
(investment may be split over two years)

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For more information call: Charles Spaeth — The Riley ■ Griffin Co. (206) 581-2300

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Western Clinic • 521 S. "K" Street • Tacoma, WA • Phone (206) 627-9151

Medical Society of Pierce County
705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

MARCH 13 GENERAL MEMBERSHIP MEETING NOTICE

THE WSMA IN "84"
"WHAT'S HAPPENING IN WASHINGTON STATE"

What is happening in the "84" session of the Washington legislature?
How will the decisions made in Olympia affect you?

- *Tort Liability Reform*
- *Mandated Medicare Assignments*

How is the WSMA addressing these issues?
What is the 1984–87 Washington State Medical Association Public Education and Patient Advocacy Program as approved by the WSMA House of Delegates at its September 1983 Annual Meeting?
The Tuesday, March 13 General Membership Meeting will address these and other questions, open to all members of the Medical Society of Pierce County.
Ample time will be offered for questions and answers.

Presentation by: Richard F. Ambur, M.D., President, Washington State Medical Association

DATE: Tuesday, March 13, 1984

PLACE: Executive Inn, Tacoma/Fife
(5700 Pacific Highway East—just off I-5)

TIME: 6:15 pm—social hour
7:00 pm—dinner
8:00 pm—program

COST: Dinner, $13.00 per person.
(price includes tax and gratuity)

Register today. Space will be limited. Mail this form, with a check for the appropriate amount, to the Medical Society in the business reply envelope provided. Or, call the office, 572-3667, to confirm your attendance. Make check payable to Medical Society of Pierce County.

REGISTRATION

Yes, I have set aside the evening of March 13 to hear "The WSMA in 84."

☐ Reserve ___ dinner(s) for me at $13.00 each (price includes tax and gratuity).
Enclosed is my check for $___.

Dr._____ Telephone _____

RETURN TO MEDICAL SOCIETY OF PIERCE COUNTY NO LATER THAN FRIDAY, MARCH 9

Hearts, Flowers, Fashion Shows and Fund Raisers

Hearts, Flowers, Fashion Show and Fund Raiser

Hearts and Flowers, Health Fairs and Dr. Lane Gerber speaking on "Romance in a Medical Marriage." What a busy February!

Fashion Show, March 16

The date of the fashion show, scheduled for April 20, has been rescheduled for March 16. Littlers will be presenting their fashions at a no-host luncheon at the Tacoma Golf and Country Club. Guests are welcome.

Fund Raiser, April 7

Auction chairman Debby McAlexander and her committee are hoping to hear from auxilians with donations of items or services. This fund raiser will be held at Charles Wright Academy Commons April 7, 7:00 P.M. A fabulous buffet will be offered, and, of course, guests are welcome.

Washington Medical Society Auxilians Convention

The Spring Washington Medical Society Auxilians Convention will be held May 1st through May 3rd at Lake Quinault. Room cost is $45 a day, double occupancy. Delegates are needed.

1984 Student Recognition Award

Attention parents of graduating seniors. The auxiliary will again present the Student Recognition Award in 1984. Eligible applicants are Pierce County high school seniors who are children of members, past or present, of the Medical Society of Pierce County. Applications are available in counselors' offices in public and private schools throughout Pierce County. Remember, applicant's names are not known to the committee during the selection process. The award is based on scholarship, leadership, service to the school and the community. Application deadline is March 23, 1984.

Janet Fry

Better Hearing is Our Business

Among those who experience hearing impairment in both ears, more than 50 percent are over 65 years of age. It is not surprising if elderly hearing-impaired persons are among your patients.

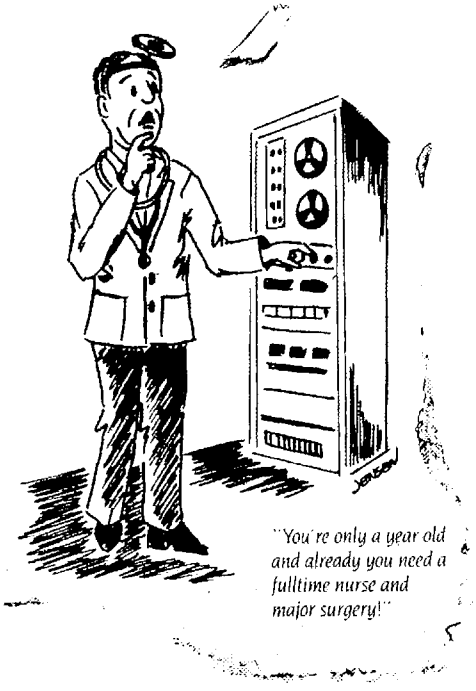
Mary Bridge Speech and Hearing Center offers:

- Five sensitive, trained audiologists licensed to dispense aids
- Aids from 10 manufacturers provide the best fit for the individual and one-stop customer convenience
- Competitive, package-priced hearing evaluations and aids
- Client reports promptly sent to primary care physicians
- Three sites: Olympia, Federal Way, Tacoma

Mary Bridge Speech and Hearing Center thanks the physician community for their support.

1220 Division Avenue
Tacoma, Washington 98405
(206) 272-1281
(206) 572-5252

COMPUTER REALITIES #1



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(509) 328-4725	(206) 682-4120	(503) 228-4783

Contacting Your Legislator

The legislature convened January 9, 1984. For a legislator, letters are the barometer that measures political pressure back home. A few thoughtful, well-written letters can often sway the vote of an undecided legislator.

If the legislature receives enough letters supporting a bill, a strong bill will pass. Letter writing tips: Ask your legislators to support your bills. Ask him to respond to you as to whether or not he will vote for it. Give reasons for your support. Cite justifications for your support. Personalize your letter.

You will be more effective if you write to your legislator as an individual citizen rather than as an organizational member. Write or type the letter legibly. Keep it short–preferably no more than one page. Include your name and address in the letter, envelopes may sometimes be lost. Remember, if you don't write, your legislator will more than likely hear from your opponents; they never hesitate to write. Follow up your letter by calling.

Listed on the opposite page are all Pierce County legislators and their Olympia telephone numbers. Key contact physicians assigned to each legislator to serve as primary sources for the 1984 legislative session are also listed.

Remember the general membership meeting, March 13, beginning with a social hour at 6:15 P.M., Executive Inn, Tacoma/Fife. Come to hear the presentation on the Washington State Medical Association facing medical concerns in 1984.

Senators	Olympia Phone Number	Key Physician Contact
2nd District		
R. Ted Bottiger (D)	753-7602	Lloyd C. Elmer, MD
25th District		
Marcus S. Gaspard (D)	753-7648	Donald C. Weber, MD
26th District		
Barbara Granlund (R)(D)	753-7650	Richard F. Ambur, MD
27th District		
Lorraine Wojahn (D)	753-7652	James H. Davidson, MD
28th District		
Ted Haley (R)	753-7654	Richard A. Hoffmeister, MD
29th District		
A. L. "Slim" Rasmussen (D)	753-7656	Stanley W. Tuell, MD

Legislative Mail Address:
Senator_____
Legislative Building
Olympia, WA 98504

Representatives	Olympia Phone Number	Key Physician Contact
2nd District		
Wayne Ehlers (D)	753-7824	James K. Symonds, MD
Duane Kaiser (D)	753-7912	Jack J. Erickson, MD
25th District		
George Walk (D)	753-7948	Thomas H. Clark, MD
Dan Grimm (D)	753-7968	Michael Haynes, MD
26th District		
Carolyn Powers (D)	753-7964	Richard Gilbert, MD
Bill Smitherman	753-7802	William B. Jackson, MD
27th District		
Ruth Fisher (D)	753-7930	Robert G. Scherz, MD
Art Wang (D)	753-7974	George Tanbara, MD
28th District		
Art Broback (R)	753-7890	Leonard B. Alenick, MD
Stan Johnson (R)	753-7958	James D. Krueger,MD
29th District		
P. J. "Jim" Gallagher (D)	753-7906	Robert G. Scherz, MD
Brian Ebersole	753-7996	Richard Hawkins MD

Legislative Mail Address:
Representative_____
Legislative Building
Olympia, WA 98504

Olympia Telephone Numbers:
WSMA Olympia Office
(24 hr. answering for messages) . . . . . (206) 352-4848
Lobbyist Message Center
(Capitol Building–"Ulcer Gulch") 754-3206
State Legislative Toll Free Message Line 1-800-562-6000

(Quick and easy way to leave messages for your legislator urging a vote for or against or to request copies of bills.)

Morning, March 9

7:30 **Welcome/Introductions/Acknowledgements**

8:00 **Cardiac and Non-Cardiac Pulmonary Edema: Update 1984**
William J. Sibbald, M.D., FRCP(C), FCCP

8:45 **Can We Afford Critical Care**
Annette Choolfaian

9:30 **Break**

10:00 **Current Treatment for Acute Respiratory Failure: Mechanical Ventilation and Monitoring**
Philip G. Boysen, M.D., FCCP

10:45 **Imaging of the Critically Ill: Conventional Chest Imaging, Computed and Ultra Tomography**
Carl E. Ravin, M.D.

11:30 **The Role of Metabolic Stress in Determining Nutritional Requirements**
Frank B. Cerra, M.D., FACS

12:15 **Lunch—Hosted**

Morning, March 10

8:00 **Chest Trauma**
Richard M. Peters, M.D., FACS, FCCP

8:45 **Bi-Ventricular Function in the Acutely Ill: A Review with Emphasis on Right Ventricular Function**
William J. Sibbald, M.D., FRCP(C), FCCP

9:30 **Threats to Renal Function in the Critically Ill Patient: Prediction? Prevention? Treatment**
Robert J. Anderson, M.D.

10:15 **Break**

10:45 **Clinical Management of the Septic Shock Patient**
Richard K. Root, M.D., FACP

11:30 **The Prevention and Treatment of Multiple Organ Systems' Failure**
Frank B. Cerra, M.D., FACS

12:15 **Lunch—Hosted**

Accreditation: ***Credits: 15 hours (potential) Based on attendance***

AMA As an organization accredited for continuing medical education, the College of Medical Education, Inc., certifies that this offering meets the criteria for fifteen hours in Category 1 for the Physician Recognition Award of the American Medical Association and for the relicensure requirements of the Medical Examiner of the State of Washington.

AAFP This program has been reviewed and is acceptable for fifteen prescribed hours by the American Academy of Family Prac

AACN-CEU (1.5 hours)

WSNA Washington State Nurses Association (CERP)

Registration: *Fees include continental breakfasts, lunches and syllabus.*

Fee: $150 Physicians
80 Allied Health
70 AACN Members

Paid preregistration is required before March 2, 1984. Registration is limited by profession.

Please address all registrations and correspondence to: *Maxine Bailey, Executive Director, College of Medical Education, Inc.*
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Workshop Selection:

		Physicians				Nurses		
Friday,	1:30-2:15	A	B	**Friday,**	1:30-2:15	C	D
	2:30-3:15	A	B		2:30-3:15	C	D
	3:30-4:15	A	B		3:45-4:30	C	D
Saturday,	1:30-3:00	A	B	**Saturday,**	1:30-2:15	C	D
	3:15-4:00	A	B		2:30-3:15	C	D
	4:15-4:30	A	B		3:45-4:30	C	D

AH = Allied Health Personnel
P = Physician

Date	Course/Topic	Coordinator(s)
February		
1/8/15	**Ethical Issues (AH)**	P. Keely, RD
9/16/23	**Nursing Pharmacology (AH)**	L. Pelham, RPh
March 1		
16/17/23/24	**Acute Medicine (P)**	T. Apa, MD
23	**Diabetes as Complicated by Pregnancy (P)** **Pregnancy Induced Hypertension** **Viral Diseases in Pregnancy**	J. Sakakini, MD
March		
2	**Urological Nursing (AH)**	M. Ramsdell, RN
9/10	**Focus: Critical Care (P) (AH)**	B. Weled, MD
23/24	**Pediatric Advanced Life Support (P)**	P. Seward, MD
April		
5/6	**Tacoma Academy of Internal Medicine (P)**	H. Retailliau, MD
13/14	**Pediatric Advanced Life Support (AH)**	P. Seward, MD
14	**Endoscopy (Auburn General) (P)**	R. Johnston, MD
28	**Days of Pediatrics (P) (AH)**	P. Seward, MD
27/28	**Tacoma Surgical Club (P)**	W. Martin, MD
May		
4	**Neurology Conference–1st Annual**	J. Griffith, MD
10/11/12	**Cardiology Conference–4th Annual**	G. Strait, MD
18/19	**Central Supply (Vancouver, B.C.)(AH)**	C. Duane
June		
7	**Total Parenteral Nutrition (P) (AH)**	L. Pelham, R.Ph.
July		
	Hospital Budget Planning (AH)	

Dates are subject to change-Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137

Managing the Business Side of Your Practice

The following article is written by Dolores Lunstrum, owner of Management Resources, a practice consulting service endorsed by your Membership Benefits Board.

This is the second in a series of articles The Bulletin will be publishing periodically from Membership Benefits, Inc., or services endorsed by the same.

Linda Carras, Director
Membership Benefits, Inc.

Given an impending physician surplus and increasing competition from many sources how can you respond? The answer is Effective Marketing.

Marketing is an ongoing process of finding out what your patients need, what they perceive their needs to be, and then matching your services to those needs.

You are undoubtedly marketing your services to some extent at this time. You use letterhead and envelopes with your name printed on them. Your appointment cards and business cards are a form of marketing. For many years, management consultants have promoted patient information brochures. These have been used to better office-patient relations; but essentially, they are a soft-sell advertisement of your services.

Many physicians now are going much farther than this to insure they will receive their share of the medical business in the coming years.

In the past five years:

One percent of physicians have located their practice in an "non-traditional" setting, such as a shopping center or store front.

Eleven percent have opened a satellite office or ambulatory care center.

Thirteen percent are using surveys to learn about patient satisfaction.

Eight percent have developed a patient newsletter.

Nine percent have advertised their practice on radio, TV, or in a newspaper.

Four percent employed an advertising or marketing firm or consultant; and four percent have developed a written marketing plan for their practice.

How do you develop a marketing program? You begin by asking yourself some basic questions and outlining the steps you will need to take.

Basic Pre-Marketing Questions:

1. *What are your choices?*
2. *Where should we go from here?*
3. *How can we get there?*
4. *What will it cost?*
5. *How are we doing?*

Marketing Steps:

1. *Evaluation of current situation; identification of opportunities and challenges (market research).*
2. *Formulation of realistic objectives.*
3. *Development of strategies*
4. *Allocation of resources.*
5. *Monitoring of results.*

Let's look at step 1. In evaluating your current situation you will want to investigate the following areas.

- *Where are your patients coming from (geographic location)?*
- *Who are your referral sources - physicians, other patients?*
- *Are patients aware of all the services offered by your practice?*
- *What services might attract patients that you are not presently offering?*
- *What individuals and/or organizations are your competition, how does their service differ from yours?*
- *Which of the procedures that you now offer are the most cost effective?*
- *Are your fees commensurate with the competition and with the economic status of your patients?*
- *Does the atmosphere of your office contribute to the satisfaction of your patients?*
- *What is the projected population growth of your area and is it relative to your specialty?*
- *Are you easily accessible to your patients, from their point of view?*
- *Where do you want your practice to be five or ten years from now?*

The answers to these questions are the basis for forming the objectives and developing the strategies to insure that your practice will survive the competition that already surrounds us. Take a few minutes to identify where your practice is at this point. Evaluate your current situation.

Future issues of *The Bulletin* will present further step by step, some methods of ethically marketing your practice and helping you plan for your future.

Dolores Lunstrum,
President,
Management Resources

Classified

For Sale–Active solo Family Practice in major medical center adjacent to hospital in Tacoma, WA. Price is negotiable, and includes leasehold improvements, fixtures, medical/office equipment and supplies, and could also include the accounts receivable for instant cash flow. 2,000 active charts. Contact P.O. Box 110577, Tacoma, WA 98411-0577.

For sale–Two, 8-month-old exam tables. 272-3520, Dr. Holm.

Medical Building for Sale–Gig Harbor, WA. Suburb of Tacoma. Quality living. Excellent downtown location. 2,885 sq.ft., includes 4 exam rooms, surgery, lab & x-rays. Commercial zoning. $265,000 on attractive terms. Equipment also available. Contact Wm. L. Hess, 3101 Judson St., Gig Harbor, WA 98335, (206) 858-6141.

For Lease–Quad Professional Building, 1st Ave. S. and S.W. 330th, Federal Way, WA. New 3-story building for Medical/Dental professionals, ready for your tenant improvements. Ownership available through lease terms. Call today for more information. Mike Miller, 244-5706 or 284-7343 (evenings). Portal West Realty.

Space for Lease–1,550 square feet in Medical-Dental complex. Dental or medical specialist wanted. Excellent exposure. Lakewood. Call Dr. Kenneth Ring (206) 584-6200.

Space for Lease–Professional complex in University Place. Two suites available, 990 sq. ft. and 1324 sq. ft. Rent is $9.00 per foot, includes electricity. Call Bud Harris, 564-6341.

Forced to Sell–Lake Steilacoom building site, 97 ft. waterfront by 477 ft. deep. Listed at $195,000, but all offers will be considered. Charmaine Island, Parkwood Realty Corporation, 581-4040 or 584-4694.

Planned Medical Building–112th near 94th, middle of valuable South Hill professional area, Puyallup. Build to suit. Call Clyde Martin, 845-9284.

Planning an Open House–Professional organizers.Invitation, food and beverage, hostessing, clean-up. FREE estimates. SUNSHINE VENTURES, 759-9354. Kari Stackpole, Suzanne Jordan.

Gig Harbor Practice Opportunity–Fully equipped medical office at Harbor Park Professional Center. Available for immediate occupancy. 1,080 square feet of space with top quality equipment. Ideal for primary-care or share with other sub-specialist. Call (206) 851-5578 for details.

GP Retiring–Walk in and take over. Reasonable terms. Beautiful Mt. Vernon, 3 blocks from hospital. 428-2626, day or night.

Tacoma & Seattle–Physicians interested in developing a practice yet who value free time are wanted for an extended hour ambulatory care clinic. Salary competitive; no night call; new facility; well-trained staff; unparalleled major city location. Applicants should be Board qualified in IM/FP/ER. Please send CV to Richard Miller, Directory of Physician Services, CHEC Medical Centers, 2200 6th Ave., No. 1200-E, Seattle, WA 98121, phone (206) 624-6888.

Plant Medical Director–Physician with experience or interest in occupational medicine, to direct preventitive health and medical program for an integrated facility, containing both wood products manufacturing and pulp paper operations. Total employment, including nearby satellite facilities in supporting woods operation, is 4,300. An on site clinic is staffed with two occupational nurses and an industrial hygienist. Excellent salary and benefits. Regular hours. Interested physicians send vita to James L. Goodman, Region Personnel Manager, Weyerhaeuser Company, P.O. Box 188, Longview, WA 98632.

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Classified advertising rates in The Bulletin, 50 cents per word, payable before publication. Minimum is$5.00.

Deadline for classifieds is the 28th of each month prior to publication. Make checks payable to Membership Benefits, Inc. Publications.

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For further information or assistance in preparing your ad call ***564-7882*** or ***564-3831.***

Letters to the Editor

In the December issue of The Bulletin a series of letters appeared under the heading Correspondence. With this issue, The Bulletin will begin publishing a monthly section devoted to letters to the editor. We welcome your letters and invite you to respond to the issues at hand.

—— the editor

To the Editor,

The president's "Parting Shot," December 1983, taking aim at the pediatric community, is off target. While Doctor Lane is not alone in seeing ghostly hospital administrators attempting to manipulate physicians' clinical judgment, greater accuracy would be served by describing the eight to ten months before physician concern for speed and quality in care of the critical pediatric patient brought effective response from administrators who were properly everwhelmed by the costs and restructuring of staff and policy required for effective care of the children within the emergency medical services system. If we must rescue our Society from ghosts and witches, our search should be for those who thought it wise for the elected president of all our members to strike out in vituperation against all our pediatric members.

The pediatric community is not alone in its pride regarding the excellence of Mary Bridge Children's Hospital. It is also not alone in its concern that fragmentation of care of critically ill and injured children may have adverse clinical effects. If there are sinister motives involved in the expression of that concern, the president should look elsewhere than to the pediatric community to find them. Far from being petty, the concern of pediatricians is that lives and health of children not be needlessly lost because of ineffective dispersion of either the medical or surgical aspects of care of the critically ill and injured.

David Sparling, MD

Society News Briefs, continued from page 4

members to stimulate members and others to action within the democratic process, and to involve more individuals in the organization.

There will be monthly programs featuring both out of town and local speakers. Joel Yudkin, Director of the Mid-Peninsula Conversion Project spoke, February 13, at Jackson Hall, on the problem of converting industries to non-military related production.

On March 11, 1984, speakers from the Enemy Mindset Symposium in Seattle will discuss how the need for enemies is created and how it fuels the international arms race. They will also address alternatives for resolving international conflicts without violence.

There is much work to be done. By sharing the load we can all learn more without overloading our already crowded schedules. The despair which can befall anyone who becomes aware of the imminent danger of nuclear confrontation becomes less as one gets involved in working to lessen that possibility. We welcome new members and inquiries. Call Diane Barnett at the PSR-Pierce County office–752-5050, or talk to the PSR contact on your hospital staff: Mark Gildenhar at Humana, Dave Pomeroy at St. Joseph, Don Maurer and Joe Jasper at Tacoma General, Bob Lane at Doctors, Bud Nicola at Puget Sound, or Ovidio Penalver at Good Samaritan. Even if you disagree with us, let's talk about our differences instead of remaining closed to new ideas and approaches to a problem that will not simply go away.

SYMPOSIUM ON THE ENEMY MINDSET

March 11, 1984

2:00 P.M., Jackson Hall Auditorium

Sponsored by
Washington Physicians for Social Responsibility
Pierce County

For information contact: 752-5050

February 1984

Membership

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Guthrie L. Turner, MD, *Preventive Medicine.* Born in Chicago, IL, 5/26/30. Howard University Medical School, 1953; internship, Madigan Army Medical Center, 7/53-6/54; residency, U.S. Air Force School of Aerospace Medicine, Brooks Air Force Base, San Antonio, TX, 7/66-6/68; graduate training, Harvard School of Public Health, Boston, MA. Washington State License, 1981. Dr. Turner is currently practicing at DSHS Division of Medical Assistance, Olympia.

Robert H. Sueper, MD, *Pathology.* Born in Lincoln, NE, 5/22/33; Creighton Medical, Omaha, NE, 1959; internship, St. Elizabeth Hospital, Lincoln, NE, 7/59-6/60; residency, University of Michigan Medical Center, 7/60-6/64; Washington State License, 1983. Dr. Sueper is practicing at St. Joseph Hospital, Tacoma.

Eric L. Platz, MD, *Emergency Medicine.* Born in Bloomington, Ind., 11/13/46; University of Texas Medical Branch, Galveston, TX, 1973; internship, Valley Medical Center, Fresno, CA, 6/73-6/74; residency, Valley Medical Center, Fresno, CA, 7/74-7/76. Washington State License, 1983. Dr. Platz is currently practicing with Northwest Emergency Physicians.

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Rental Suite Also Available

Gary Allyn R.E.

TACOMA BEAUTIFUL. Magnificent mansion, 4,950 sq.ft., 5 bedrooms, 4 baths. Ornate ceiling moldings. Oval living room with built-in bookshelves, marble fireplace; huge formal dining room for lavish entertaining adjacent to butler's pantry with ample china and crystal storage. Floods of natural light and exquisite vintage light fixtures highlight European wall coverings. Master suite has own bath, huge bedroom, sitting/dressing room with fireplace, large walk-in closet. Property includes attractive carriage house, oversize lot, many beautiful trees and shrubs. $235,000.

BRICK FEDERALIST. Handsome, classic 4 bedroom, 2½ bath home in the heart of the Stadium-Seminary district. Entry foyer with broken pediment leads to gracefully curved open staircase. Well maintained, with all the trappings of the period. Excellent landscaping, sprinklers, raised garden beds with enriched soil, fruit trees. Security and fire alarm systems. Excellent price. $145,000.

BEAUTIFUL STADIUM WAY. Privacy, superior view, fine detailing of functional inner space identify this comfortable well-kept 3 bedroom, 2 bath family home. One of the best views in Tacoma. $199,500.

EXCLUSIVE GARFIELD ROAD, VIEW. One of Tacoma's finest view homes. 5,000 sq.ft. with room for quality family living and amenities for grand entertaining. $269,500.

UNIVERSITY PLACE, VIEW. 4 or 5 bedroom American classic. The oversize living room has beam ceilings and a huge tiled fireplace featuring Mt. St. Helens and Spirit Lake. Excellent view of Fox Island and Olympics from living room. Formal dining room and expansive master with mahogany built-ins. Home is perched on a nicely landscaped ¼-acre site with 2 rare giant cedars. There's a fine view from the lower level family room with wet bar and wood stove. $83,000.

3316 N. Proctor - **(206) 752-3565**

Alan Liddle Designed Contemporary View Home North End To Be Built Soon

EMERY CONSTRUCTION

Phone for appointment to see plans:
BOB EMERY 272-6749
223 Tacoma Ave. South, Suite D
Tacoma, Washington 98402

Nutrition and the Physician

Are you being bombarded with nutritional information? Are your patients taking valuable time asking about the newest fad diets? If so, contact a registered dietitian (R.D.) to assist you.

The R.D. (Registered Dietitian) that you see after a name means that person has completed all of the following:

- Bachelors degree in dietetics and nutrition.
- Internship or work study program.
- National registration examination.
- 75 credit hours of continuing education courses every five years to remain registered.

Dietitians practice in health care facilities, such as hospitals or nursing homes where they concentrate on administrative or clinical tasks. They are also found in private practice, public health departments, agencies and businesses that provide nutrition education. Dietitians are willing to share their knowledge by speaking to professional and community groups.

An R.D. strives to provide optimal nutritional care for all people and identify those at nutritional risk. Physicians may order nutritional assessments for their patients. Diets are modified to meet individual needs and preferences.

In order for an R.D. to provide quality nutrition education it is recommended that physicians give advance notice. This facilitates inclusion of family members, decreases distractions, and allows time for individualized instruction. Follow-up instructions are available in the health care setting or by R.D.'s in private practice.

Registered dietitians can assist you with specialized parenteral and enteral feedings. Dietitians can inform you about available feedings and can recommend appropriate types and amounts to be administered. The nutritional adequacy of tube feedings and TPN solutions are recorded on the patient's chart. Dietitians use the patient's chart to obtain pertinent information for their assessment of a patient's nutritional status and to record updated information on the patient's nutritional progress.

Dietitians are your nutrition resource person on the health care team. Could an R.D. assist you in your patient care?

Jo Anne Scott Priebe, R.D., M.P.H.
Jean Macy, R.D.
Southern Puget Sound Dietetic Association

Publish Your Article in *The Bulletin*

The Bulletin would like to take this opportunity to invite physicians and other medical personnel to submit articles pertinent to the medical profession for publication in future issues of *The Bulletin*. Articles submitted for publication should be typewritten with the name, address and phone number of the physician or individual responsible for the article.

Send all typewritten manuscripts for publication to the Medical Society of Pierce County, c/o Douglas Jackman, Managing Editor, 705 South 9th, Tacoma, WA 98405

Note to members of the Medical Society of Pierce County regarding the 1984 PICTORIAL DIRECTORY: Dr. Reitzig's photo was erroneously printed out of sequence on page 65 in the Pictorial Directory. It should have appeared on page 51. Our apologies.

An added complication... in the treatment of bacterial bronchitis*

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy— Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy— Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal: symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor®, cefaclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain— Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic— Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic— Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal— Slight elevations in BUN or serum creatinine (less than 1 in 500), or abnormal urinalysis (less than 1 in 200).

INSERT

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother. 8:91, 1975.
2. Antimicrob. Agents Chemother. 12:479, 1977.
3. Antimicrob. Agents Chemother. 13:584, 1978.
4. Antimicrob. Agents Chemother. 12:299, 1977.
5. Current Chemotherapy, edited by W. Siegenthaler and R. Luthy, p. 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother. 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases, edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett, p. 487. New York: John Wiley & Sons, 1979.

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300056

MEDICAL SOCIETY OF PIERCE COUNTY
705 South 9th, Suite 203
Tacoma, Washington 98405
ADDRESS CORRECTION REQUESTED

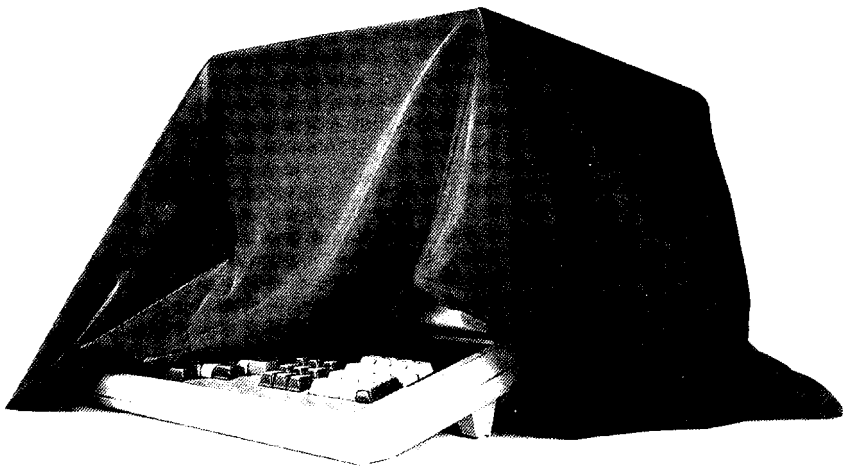
The Bulletin

March, 1984

MEDICAL SOCIETY OF PIERCE COUNTY

In This Issue . . .

On March 1, it became far easier to choose the right medical computer system.



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The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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Summary of Medical Society and Local Community News

SOCIETY NEWS BRIEFS

MAMC-MSPC Meeting Set for April 3

The annual joint meeting of the Medical Society of Pierce County and Madigan Army Medical Center will be held Tuesday, April 3.

See page 12 in this months *Bulletin* for meeting announcement and registation.

This year's program will feature four brief scientific presentations, an excellent meal, and the opportunity to meet your colleagues from MAMC and share an always delightful evening.

Registration forms were mailed to all members earlier in March. Please respond by March 28, or call the Medical Society office (572-3667) at your earliest convenience.

Perform A Death Defying Act Learn C.P.R.

Performing C.P.R. can truly be a death-defying act. The EMS Division of the Tacoma-Pierce County Health Department, acting as the American Heart Association's county center for C.P.R. training, is hoping to coordinate the C.P.R. training of 30,000 citizens in 1984.

The EMS Division in conjunction with the American Red Cross and the Tacoma Stars is sponsoring a large C.P.R. training class at the Tacoma Dome, March 24, 1984, 2:00 to 5:00 P.M. The first 300 registrants will receive free tickets to the Stars game that evening. The class is free.

The EMS Division can also provide instructors, manikins and training supplies for individual classes. Physicians wishing to have their office staff C.P.R. trained should contact the EMS Division office. Additionally, C.P.R. classes for the family and co-workers of high risk cardiac patients are available. Special C.P.R. classes for physically handicapped citizens can also be arranged.

If you would like to schedule a C.P.R. class or register for the Tacoma Dome C.P.R. class, call the EMS Division at 591-5747.

Special Thanks to Society and Auxiliary Volunteers

Mrs. Wayne (Sally) Larson is to be congratulated for coordinating the volunteer effort of nearly forty Auxiliary and Society members to man the Tacoma Mall Health Fair booth on February 17, 18, and 19. This was the long President's Day weekend and many thanks to the volunteers for their contribution of time for the benefit of the community, Auxiliary and Society. (See Auxiliary News, page 16, for more details.)

Sound-to-Narrows Fun Run

The Sound-to-Narrows Fun Run will take place Saturday, June 2 this year. The Society has provided volunteer physicians to help man the first aid tent at the finish line in previous years. We are once again seeking volunteers for the 1984 Fun Run. Over 9,000 runners are expected to take part in the Fun Run. If you are interested in volunteering approximately five hours to assist in the first aid tent, call the Society office, 572-3667.

Tel-Med Brochures Available for Your Waiting Room

Tel-Med operators averaged approximately 2,000 calls during January and February, 1984. With a good marketing program, we believe this number can be increased considerably.

Do you have space available in your waiting room for 25 to 40 Tel-Med flyers? Doctor's waiting rooms have proven to be an excellent source of distribution for the Tel-Med brochure, and your assistance would be appreciated.

Society of Adolescent Medicine Holds Spring Meeting, May 4 and 5

The Society of Adolescent Medicine will hold its spring meeting May 4 and 5, 1984 at the Marriott (Sea-Tac) Motel. Topic of the meeting will be "Adolescent Health: A Shared Responsibility."

Subjects such as anorexia nervosa, sexuality, drug abuse and dealing with the nuclear age will be presented. The program is supported by the Washington Interscholastic Activities Association, School Nurses Organization of Washington, Washington Alternative Learning Association, Washington Association Concerned with School-Age Parents and Educational Service District No. 121.

Inquiries should be directed to Charles L. Abernathy, Program Chairman, NWSAM, Clover Park School District A-I School, 5214 Steilacoom Blvd, Tacoma, WA 98499, Phone: (206) 756-8495.

EMERGENCY MEDICAL SERVICES A YEAR OF PROGRESS

1983 was a year of major progress for the Tacoma-Pierce County emergency medical services (EMS) system. The EMS Medical Control Project, sponsored by the Medical Society of Pierce County and the Pierce County EMS Council, was absorbed by the Tacoma-Pierce County Health Department in January 1983.

The staff of the medical control project was employed by the health department to coordinate the administrative components of the county EMS system. Dr. Mark Jergens replaced Dr. Terry Kendrick as EMS medical program director in May. The EMS Division remained at the Medical Society's headquarters until October when it was moved for a brief period to the health department.

A rapid growth of staff and responsibilities necessitated a second move in January 1984 when the EMS Division found a permanent home in the space formerly occupied by the Tacoma emergency management department at 420 South Fawcett, Tacoma. An organizational chart of the EMS Division appears on page 8.

The Medical Society of Pierce County and the Pierce County EMS Council continue to function as primary advisory bodies to the EMS Division. An organizational chart of the EMS Council appears on page 8. The EMS Division, working in concert with the Medical Society and EMS Council, initiated several important projects in 1983. A summary of several of the projects follows:

20,166 Tacoma-Pierce County residents received C.P.R. training. The EMS Division acts as the coordinator in Pierce County to provide citizen C.P.R. training through the auspices of the American Red Cross, the American Heart Association and the Department of Labor and Industries.

The EMS Division operates a C.P.R. hotline which plays a 24 hour-a-day

tape-recorded message of C.P.R. classes. Additionally, the EMS Division provides instructors, movies, training manikins and supplies for C.P.R. classes.

540 emergency medical technicians (EMTs) received both written and practical examinations conducted by the EMS Division. These EMTs form the foundation for the Pierce County EMS first provider services. Recertification/examination is required every three years.

Pierce County developed a new practical examination for EMTs utilizing a thirteen-page computer enhanced form. This new format has since been reviewed and adopted, with minor modification, by the Washington State Medical Association's EMS Committee (of which Dr. Jergens is a member) as the state standard for EMT practical examination.

In 1983 Pierce County launched the first county-wide medical anti-shock trouser (MAST) program in the state. The education, examination and certification process developed by Pierce County is now accepted as the state standard. Approximately 200 Pierce County MAST technicians were certified in 1983.

In March 1983, Pierce County became the first county in Washington State to adopt the National Registry paramedic examination as the standard testing format for certification. The Washington State Medical Association's EMS Committee has since followed Pierce County's lead and has recommended the National Registry exam for state-wide use.

Pierce County administers the combined written/practical exam three times a year attracting examinees from throughout the country in addition to Pierce County and Washington State. County paramedics are required to recertify/examine every two years.

The EMS educational process has been stabilized through the audit/review of EMT and paramedic training programs and the subsequent designation of Tacoma Community College as the Pierce County EMS training institution.

A major review and reorganization of the curriculum of paramedic training to place much more emphasis

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EMS MEDICAL CONTROL ARE WE ANY CLOSER?

Recognition of the need for a greater role of the Medical Society and its members in the control of emergency medical services (EMS) in Pierce County dates back to the late 1970s. Planning for the Medical Control Project began in 1980 with eventual funding of the project by the state and the Medical Society in October 1981. Since that time emergency medical services in Pierce County have improved and changed dramatically. The article on page 6 in this month's *Bulletin* outlines some of the projects undertaken and accomplished. The short synopsis belies the complexities of these accomplishments.

Additionally, with the support of the Washington State Medical Association's EMS Committee and the State Department of Social and Health Services support, the new state law governing emergency medical services (passed July 1983) greatly enhances the power and protection of local EMS medical program directors and better defines the relationships of ALS supervisory physicians assisting the medical director.

Though several components of emergency medical services have undeniably improved in the past two and a half years, we must ask ourselves, has medical control of the paramedics' performance of their duties improved? Has physician control of what actually happens at the scene of an extrahospital emergency in Pierce County changed in the past two and a half years?

The answer to these questions is undoubtedly "Yes." One need look no further than the accompanying article in this month's *Bulletin* to find significant impact. Specifically, the designation of a single EMS training site, significant restructuring of that institutions's paramedic training curriculum, the addition of an active ALS training physician (Dr. Roger Simms) and two clinical coordinators to work closely with me, has significantly improved the quality of paramedic training and should lead to improved paramedic field performance.

The implementation of a meaningful certification and recertification exam for certified paramedics has significantly improved credibility and established an expected standard level for field performance.

Lastly, the development, review and implementation of patient care treatment guidelines allow a standard measure of performance of paramedics and physicians, as well as providing an education and audit tool.

But is this enough? The answer to this question is undoubtedly "No!" As important as these first steps have been in improving credibility, standardization, and to some extent field care by paramedics and paramedic students, they are clearly only the easy first steps. Several significant problems prohibiting real medical control continue to exist.

First, there is much physician inconsistency. Currently every hospital in Pierce County with a physician on duty and a HEAR radio may direct patient care via paramedics. All too often these physicians have little knowledge of the paramedics' previous training, skills abilities, drug availability, recommended treatment guidelines or the EMS system in general.

As many as 75 physicians, generally with little training or experience with Pierce County's EMS system or personnel, may at any one time direct patient care. A license to practice medicine or being on duty in an emergency department should not be the single criteria for directing paramedics in Pierce County.

How many physicians who direct patient care via paramedics have ever spent field time with paramedics in Pierce County? How many have reviewed EMS charts to determine appropriateness of patient care or to determine the level of performance of a paramedic? How many familiarized themselves with paramedic training, certification or recertification?

Likewise, Pierce County continues to have no effective data collection or retrieval system. In fact, there is not even uniformity of EMS medical charts for all ALS agencies in Pierce County. It is still currently impossible to tell how many first responses for medical aid occur per month in our county, much less a method to document performance by individual EMS personnel.

Significant improvement in chart audit by the ALS supervising physicians reviewing the individual performance of the paramedics of the ALS agencies they represent has occurred over the past year. However, there remains no mechanism for coordination of data.

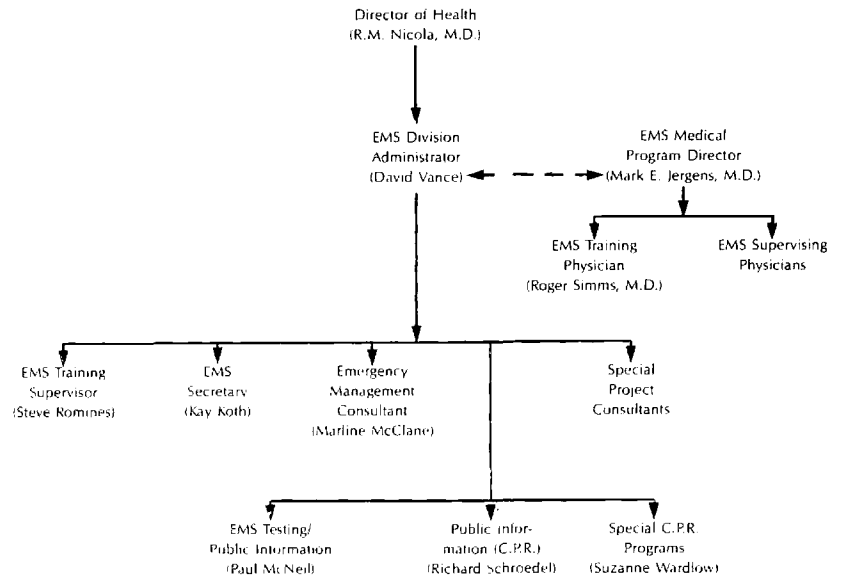
Further, a paucity of continuing medical education programs for certified paramedics, no review of tape records for education or performance and no overall coordination of continuing education exists in Pierce County.

To avoid the risk of sounding like a doomsayer, let me again reiterate that significant physician impact on paramedic performance and credibility has been made, but no one should think medical control has arrived in Pierce County. This is not the time for sitting back or sitting on hands — there is much to be done.

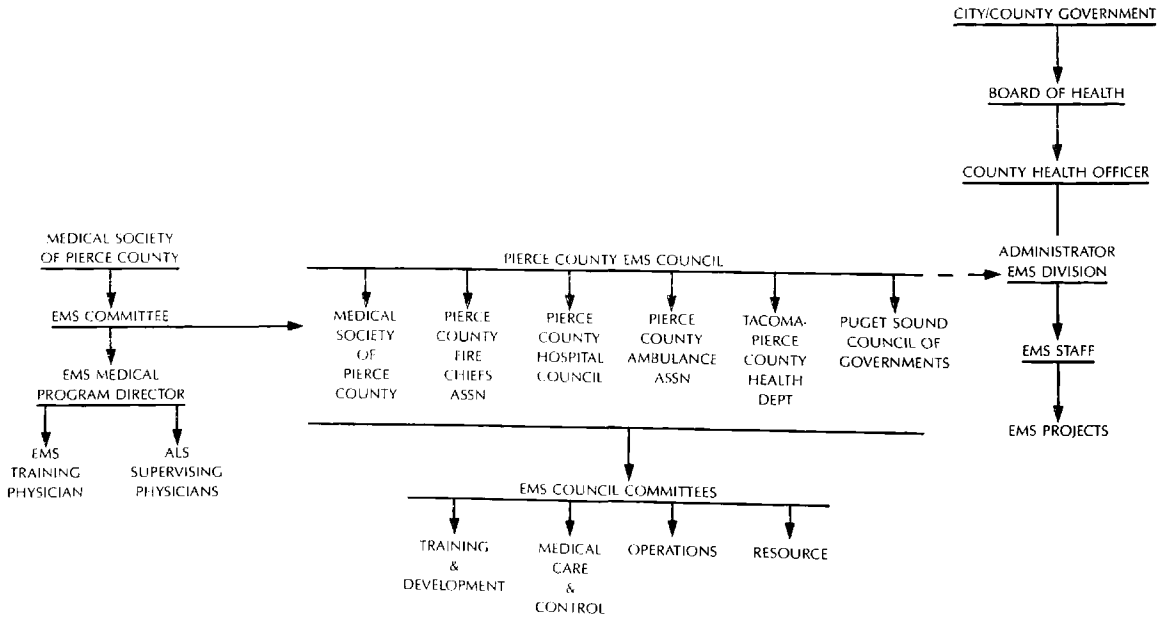
Several members of the EMS Committee of the Medical Society developed and distributed a proposal for medical control that addressed the bulk of the problems of physician inconsistency, data collection, tape review and continuing education.

continued on page 9

ORGANIZATIONAL CHART
EMS DIVISION
TACOMA-PIERCE COUNTY HEALTH DEPARTMENT



ORGANIZATIONAL CHART
PIERCE COUNTY EMERGENCY MEDICAL SERVICES



Emergency Medical Services: A Year of Progress continued from page 6.

on clinical training, including defined clinical exit requirements, has been accomplished. A nurse and a paramedic clinical coordinator were hired to provide extra teaching and coordination.

Dr. Roger Simms was hired as the county EMS training physician to oversee the didactic and clinical portions of this training. Dr. Simms has worked closely with Dr. Jergens and the Tacoma Community College staff to implement this curriculum restructuring.

Patient care protocol/guidelines have been published after an exhaustive development and review process by Dr. Jergens and the EMS Committee of the Medical Society. Pierce County now has the most extensive patient care guidelines of any county in the state.

These guidelines provide specific medical direction for both pre-hospital and emergency department personnel, set a standard for patient care and serve as an educational and audit tool for EMS personnel. These guidelines have been distributed to all paramedics, ALS provider agencies, ALS supervising physicians and emergency departments.

During 1983, the process was initiated for the designation of emergency receiving centers, base station hospitals and a trauma center. The designation of these institutions, following previously adopted criteria, is continuing into 1984. The Operations Committee of the EMS Council is presently considering several options for the county base station system.

Other projects conducted by the EMS Division in 1983 included ongoing coordination for the initiation of the 9-1-1 system, scheduled for switchover in September 1985; consolidation of EMS dispatch centers; coordination of the May 1983 EMS awareness show at the Tacoma Mall; evaluation of the county disaster exercise; planning for initiation of the ultra-high frequency medical communications system and improved emergency preparedness through the assumption of some of the responsibilities of the Tacoma department of emergency management.

Through 1984 the EMS system will continue to mature and stabilize as goals and objectives originally established by the Medical Society and other groups are achieved.

For further information contact: EMS Division, Tacoma-Pierce County Health Department, 420 South Fawcett, Tacoma, Washington 98402, 206/591-5747.

David Vance

David Vance is Administrator for the Emergency Medical Services Division, Tacoma-Pierce County Health Department.

Emergency Medical Control: Are We Any Closer? continued from page 7.

The "Base Station Proposal" was based upon successful EMS systems elsewhere. Several months have been spent explaining, modifying and discussing the implementation of this proposal in Pierce County. It does not solve all the problems or meet everyone's needs, and it will require fine tuning after implementation to work effectively in Pierce County.

Currently that proposal and a spinoff "single, non-hospital base station" are undergoing review in the EMS Council's Operations Committee, but serious geopolitical pressure threatens to prevent its adoption or implementation any time soon.

Meanwhile, we move no further toward effective medical control. We have imposed many restrictions and requirements on paramedics and EMTs over the past two and a half years; we must not fail to make tough decisions to designate physicians and hospitals responsible for medical control and expect responsible action on their part after designation.

Thank you for your continued support of emergency medical services in Pierce County.

Mark E. Jergens, MD, FACEP
Chariman, EMS Committee, Medical Society of Pierce County
EMS Medical Program Director, Tacoma-Pierce County Health Dept.

All orders for pictorial directories have been filled. Extra copies are now available for purchase. If you have not received your complimentary or ordered copies, please call Linda Carras, 572-3709, Medical Society of Pierce County, Membership Benefits, Inc., Publications.

DEFEATING DISCRIMINATION OR TRIVIAL PURSUIT

There's a new game in town. Subject matter, trivia. Cost, $40.00. It's the brainchild of some deft hockey players who exchanged their handling skill of the golden puck into the rewards of the golden buck. And for all you trivia lovers, this hot game was conceived over two cold beers. It's been sold out at most stores since it hit the market.

Whether you know it or not, you play a real life game not too dissimilar. Defeating Discrimination.

Superficially, Defeating Discrimination resembles Trivial Pursuit. Employers must recall details in minutae that most persons would prefer to forget. For example, which data can you request on an employment application—birth date or age? Trivial, you say, a mere word game, semantics. The writers of the rules didn't view discrimination that way.

The difference in the two games is clearly one of risk. Losing at Trivial Pursuit may be a humbling experience but discriminators who disregard rules pay high fines and sometimes end up in the penalty box, jail. Avoidance has cost others their practice.

Let's simplify the rules of this game and develop a winning strategy.

Avoid the following red letter words:

Sex, Age, Marriage, Children, Race, Handicap, Religion.

Use these green letter words freely: availability, dependability, responsibilities, commitments, long term goals.

Get a copy of the rule book, *Pre-Employment Inquiries and Screening.* Read it. It lists side by side fair employment questions against unfair questions. The book is available from the Washington State Human Rights Commission or my office.

Get a sample copy of a non-discriminatory application form, available from the same sources.

In defeating discrimination the main objective is to learn what you need to know without breaking the rules, i.e., asking illegal questions.

Your strategy should be to outline requirements that are germane to the position. Devise pertinent, legal questions, and you'll get relevant answers. Use your rule book as a reference guide. It has several questions you may wish to copy verbatim.

In outlining requirements look for commitment, someone willing to work x number of years; dependability, someone who is punctual and appears daily; availability, someone who can work overtime without notice; efficiency, someone who does the task well in a given time frame; personality, someone who interrelates well with staff and patients.

In asking pertinent, legal questions consider the following as possibilities: In this office you need to be available to work on call or an occasional Saturday, would this ever present a problem? What is the minimum number of months/years you expect to work here? Sometimes we work overtime, do you have any responsibilities that would interfere with working until 7:00 P.M. without prior notice?

Whether the applicant has five children in daycare or two giraffes to feed at 5:30 promptly is irrelevant.

If the individual is there when you need them and does what is assigned, all other personal details are trivia.

If someone volunteers personal information that could be considered discriminatory (red letter words) re-word the information into non-discriminatory language before writing it down. An example might be, available evenings, outside responsibilities pose no interference. Keep in mind that you are accountable for your records.

Look at work history and reflect on the applicant's patterns. Have they relocated often. Listen carefully to their reasons for leaving previous employers and trust your own feelings if you believe the applicant is a worthwhile risk.

Finally, review your application form. Be certain that it is legal.

You now have some tactics to assure you of employing the best candidate while not practicing any discriminatory acts. The most difficult part in defeating discrimination is accepting what one wants to know is not always what one needs to know.

If you're frustrated defeating discrimination and consider it trivial pursuit, remember, it is the law. Then call me. I'm here to help. 572-3709.

Linda Carras, Director
Membership Benefits, Inc.

The February *Bulletin* presented an article, *Managing the Business Side of Your Practice,* by Dolores Lunstrum, President, Management Resources. We neglected to give credit to the AMA Department of Practice Management for source material. Material for the article was taken from *Marketing Strategies for Private Practice,* copyright 1983, published and distributed by the AMA Department of Practice Management.

the editor

Interprofessional Committee Report

CONFUSING OR INFORMING YOUR PATIENTS

Your Interprofessional Relations Committee had its first meeting of 1984 and had the opportunity to greet a new member, Dr. Sid Kase, who was given a hearty welcome. Dr. Kase has volunteered his services to the Society.

Many interesting topics were discussed during a good breakfast served by our faithful waitress of seven years, Patty, who never forgets an order.

The committee discussed the problem of giving information to a patient about a drug prescribed for them and that patient's ability to understand what he is told. While some instructive information is necessary, too much can be confusing and even alarming to the point where the patient is fearful of taking even the first dose.

The occasional patient will, by virtue of suggestion alone, sooner or later have one or all of the side effects he or she learned could occur. The best method, it was decided, was to acquaint the patient with the real side effects rather than the "it could possibly happen" type, and reassure them that if the doctor prescribed the medication in the first place, he certainly thought it was necessary for the welfare of the patient.

We have to temper our educational efforts accordingly and work together as pharmacists, physicians, podiatrists, dentists and nurse practitioners alike.

It was brought to the committee's attention that there has been approximately a 40 percent decline in the number of military physicians at our nearby bases, resulting in a long, long wait for patients waiting to see a physician.

Unfortunately, due to the regulations regarding prescription refills, it is now taking longer to get a prescription in the first place and longer to get a refill, even if authorized.

Therefore, expect more of your military dependents to demand updated prescriptions or prescriptions at local, civilian pharmacies. This is no problem for the local civilian pharmacists, but it occasionally can be for the civilian physician.

Several pharmacist members of the committee expressed hope that the control of pharmacies in our state would never be switched from their present status under the State Board of Pharmacy to the State Board of Licensing.

Pharmacists warn that if this should occur the present, although woefully small, number of pharmacy inspectors (three for the entire state) would be reduced to simply paper shufflers. I do not understand this, but I have learned to respect the pharmacist members of the committee sufficiently to know that they know what they are talking about.

The *Hotline* is still effective. Andy reported that he used it the other day to stop multiple prescriptions for a patient going from one pharmacy to another.

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Medical Society of Pierce County
705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

Medical Society/Madigan Army Medical Center

ANNUAL JOINT MEMBERSHIP MEETING

Join your colleagues from the Medical Society and Madigan Army Medical Center for dinner and informative and entertaining program of four presentations (one hour AMA Category I credit will be awarded).

PROGRAM

- **Aging and Testicular Function**
  Colonel Stephen R. Plymate, M.D., Department of Clinical Investigation
- **Hepatitis B Vaccine—Current Concepts and Strategies**
  Captain David Fletcher, M.D. Preventive Medicine Activity
- **Spinal Computed Tomography (CT) Scanning in the Evaluation of Metastatic Disease**
  LTC John Redmond, M.D., Department of Medicine
- **Adult Typhlitis: Neutropenic Cecitis, Diagnosis and Treatment**
  MAJ Verle D. Bohman, Department of Medicine (Gastroenterology Service)

DATE:	Tuesday, April 3, 1984
TIME:	No host cocktails 6:15 P.M. Dinner 7:15 P.M. Program 8:00 P.M.
PLACE:	Fircrest Golf Club, 6520 Regents Blvd., Fircrest. (Take Fircrest exit off of Hiway 16. Proceed on Regents Blvd. to the club which will be on your left.)
COST:	Dinner, $11.50 per person.

Register now. Please complete the attached reservation form and return it, with a check for the appropriate amount **made payable to the Medical Society of Pierce County,** in the enclosed pre-addressed envelope. Or, call the Medical Society office, 572-3667, to confirm your attendance.

Due to the special arrangements necessary for this joint meeting, reservations must be made no later than Friday, March 30.

REGISTRATION:

Yes, I (we) have set aside the evening of April 3 to join my fellow Society members and physicians from Madigan Army Medical Center at the Annual Joint Meeting.

__ Please reserve _____ dinner(s) at $11.50 per person (tax and gratuity included). Enclosed is my check for $_____.

__ I regret I am unable to attend the dinner portion of the meeting. I will attend the program only.

Dr.:_____

RETURN TO MSPC BY NO LATER THAN FRIDAY, MARCH 30

TACOMA ACADEMY OF INTERNAL MEDICINE

April 5, 6, 1984
Tacoma General Auditorium, Jackson Hall
314 South 'K' Street,
Tacoma, Washington

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il 5 — Thursday

ıtinental Breakfast/Registration
lcome & Introductions

FECTIOUS DISEASE & IMMUNOLOGY

e Influence of Immune Response Genes on the Expression of Disease	John D. Stobo, MD
ld & Other Remititive Agents	Ronald L. Kaye, MD, FACP
eak	
by the Bacteria Keep Winning	Richard E. Dixon, MD, FACP
by the Viruses Keep Winning	John Sullivan-Bolyai, MD, MPH

ınch

ıpril 5 — Thursday

LINICAL PHARMACOLOGY

ıtidepressants — Choosing the Right One	Donald L. Dudley, MD
ıeophylines Comparison to B_2 Agonists in Outpatient Management	John J. Jenne, MD
eak	
'amination of the Shoulder Joint & Techniques for Injection	David E. Karges, MD

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ril 6 — Friday

:CHNOLOGY & OUTPATIENT CARDIOLOGY

ansluminal Angioplasty — The Local Experience	Edmund E. Lewis, MD
cemakers — The Pros & Cons	Thomas A. Preston, MD, FACC - FACP
w Pharmacologic & Technical Advances in Diagnosis & Management of Hypertension	Robert C. Davidson, MD
nel Discussion: Technology's Impact on Outpatient Cardiology	Morning Speakers and Needham E. Ward, MD

nch

pril 6 — Friday

JLMONARY DISEASE

ısocomial Pneumonias	Richard E. Dixon, MD, FACP
ysiology of Respiratory Monitoring in the Intensive Care Unit	Barry E. Weled, MD
ımp the Professor (You) with Wierd Chest X-Rays (all attendees invited to bring their own)	Gilbert J. Roller, MD

• Program Coordinator: Henry F. Retailliau, MD •

Category I — 14 Hours AMA-AAFP

TION

fee for non-members $75.00 *(Fees will not be refunded , 1984)*

RESERVATIONS BY ALL WISHING TO ATTEND IR ARE REQUIRED BEFORE APRIL 2, 1984.
dues include dinner for the member only. The dinner ur spouse or guest and non-members will be billed.

all correspondence, inquiries, and registrations to:
y, Executive Director
edical Education, Inc.
h, No. 203, Tacoma, Washington 98405
7

ALL WHO PLAN TO ATTEND ARE ASKED TO RESPOND
PLEASE FILL OUT AND RETURN

☐ I am a member ☐ I am not a member of the Tacoma Academy of Internal Medicine and will be attending the educational session on April 5, 6, 1984.

☐ I will be attending the dinner Friday evening April 6, 1984: please make reservations for _____ in addition to myself and bill me at the address listed below:

_____
Name

_____
Address

s please enclose check for $75.00 payable to the College of Medical Education.

The College of Medical Education does not discriminate against those participating in any of its activities regardless of sex, race, creed or religious sect.

Date	Course/Topic	Coordinator(s)
March		
23/24	**Pediatric Advanced Life Support (P)**	P. Seward, MD
April		
5/6	**Tacoma Academy of Internal Medicine (P)**	H. Retailliau, MD
7	**Trauma Nursing (AH)**	A. Chilton, RN S. Badassi, MD
13/14	**Pediatric Advanced Life Support (AH)**	P. Seward, MD
14	**Endoscopy (Auburn General) (P)**	R. Johnston, MD
28	**Day of Pediatrics - Future Trends (P) (AH)**	R. Scherz, MD
27/28	**Tacoma Surgical Club (P)**	W. Martin, MD
t/b/a/	**Recovery Room Topics**	P. Shull, MN
May		
4	**Neurology Conference - 1st Annual (P)**	J. Griffith, MD
10/11/12	**Cardiology Conference - 4th Annual (P)**	G. Strait, MD
18/19	**Central Supply (Vancouver, B.C.) (AH)**	C. Duane
	Advanced Pediatric Life Support (P)	P. Seward, MD
June		
7	**Total Parenteral Nutrition (AH)**	L. Pelham, R.Ph.
July		
	Hospital Budget Planning (AH)	

Dates are subject to change-Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137

Interprofessional Committee Report, continued from page 11

One last reminder. Don't forget, if you prescribe Ritalin, you must document your prescription as well as in your records that the drug is being prescribed for narcolepsy. I recently got "took" by this from a man reportedly from California who was bearing all the papers to show he had the disease. When I wrote to California, they had never heard of him! Goes to show you, you can't trust everybody, regretfully.

Herman S. Judd, MD, Chairman,
Interprofessional Committee.

D.R.G. MADNESS

Effective Oct. 1, 1983 hospital payment for Medicare patients will be based on Diagnosis Related Groups. Each patient will be assigned to one of 468 Diagnosis Related Group (DRG) classifications based on the documentation in the Medical Record at discharge. Hospitals then will be reimbursed at the fixed rate for that particular DRG.

The strange examples listed below show how financially important it will be to use certain diagnoses. Can you guess which diagnoses are going to be most popular?

DRG No.	*Principal Diagnosis*	*Rate*
438	Alcoholism with Cirrhosis	$1,920
202	Cirrhosis with Alcoholism	2,692
391	Newborn with Neonatal Jaundice	691
389	Newborn with ABO Incompatibility Jaundice	1,175
373	Term Pregnancy, Delivered	1,398
372	Pregnancy Delivered, Postpartum Hemorrhage	1,625
297	Dehydration with Gastroenteritis	1,500
182	Gastroenteritis with Dehydration	1,969

From: Hospital Practice

ANNOUNCEMENT

Please be watching for Membership Benefits Annual Salary and Fringe Benefit Survey in your office mail. Your cooperation in answering the questionnaire and prompt return will facilitate our getting the results to you as soon as possible.

This service has been most valuable in the past to employing physicians and will assist you in evaluating what the current market value of labor is in Pierce County for medical staff.

Thank you.
Linda Carras, Director
Membership Benefits, Inc.

Auxiliary News

GEARING UP FOR '84-85

Plans for the 1984-85 auxiliary year are being made right now! I would like your input so the auxiliary will have something to offer you during the coming year.

Call me at 564-6647 with your concerns or ideas for general membership programs (speakers, tours, etc.); alternatives to holding monthly meetings in private homes; possible subjects for interest groups; new areas to provide volunteer community service; and/or fund raisers.

Programs, luncheons, outings, fund raisers and community projects take a great variety of skills and committee members, skills which you may have and would like to keep sharp. If you can do any of the following, you could support both the medical community and the public: type, hand address mailers, run computer programs, prepare luncheons, write grant proposals, draw, letter, teach, write newsletters or *Bulletin* articles, make public relation contacts with media personnel and/or do other committee work.

If you reach my recorded telephone message, please leave your name and number as well as your suggestions, concerns or skills. If you don't like to talk to machines, just leave your name and number, and I will return your call.

Sharon Ann Lawson, President-elect

Auxiliary Auction: Don't Miss It

Fun! Food! Fundraiser! Right this way to the event of the year. Back again by popular demand, the PCMSA Auction will be held Saturday, April 7, 7:00 P.M., in the Charles Wright Academy Commons. Admission fee is $8.00 per person which entitles you to a gourmet buffet, participation in a silent and oral auction, plus the fascinating company of some of the most charming and entertaining people in the Pacific Northwest. Reservations for this—not to be missed—event can be made with Debbie McAlexander, Judy Brachvogel and Florence Dean, Gig Harbor.

Tacoma Mall Health Fair Brings MSPC and PCMSA Together

President Day Weekend brought the MSPC and PCMSA together to man a joint booth at the Tacoma Mall Health Fair. Sally Larson reported on the event. Brochures were distributed telling about Tel-Med, organ donations, important numbers for the elderly, Whozit sheets and eye care sheets. Blood pressures were taken for 23 hours.

Everyone worked hard and projected the two organizations as medical families caring about our community—a vitally important message and reality the public needs to see.

Those working were: Sophia Chan, Jo and Gil Roller, Alice Hilgar, Nicki Crowley, Sharon Lawson, Cindy Anderson, Richard and Sonya Hawkins, Ray and Gloria Virak, Stan and Stephanie Tuell, Martin and Mary Schafferle, Cynthia Wilson, Tom and Sandra Irish, Bob and Helen Whitney, Charles and Shauna Weatherby, Howard and Barbara Wong, Thomas and Mary Lou Jones, Kris and Matt White, Dick and Sharon Gilbert, Ray and Ginny Miller, Bob and Debbie McAlexander and Wayne and Sally Larson.

A special thanks to Sophia Chan for helping to decorate the booth and to Cindy Anderson for working a double shift. Thanks also to Doug Jackman who helped set up the booth, rented the television, purchased the little things the booth needed at the last minute, worked the last shift and dismantled the booth.

Everyone named here made the booth a big success and deserves the Auxiliary and Society's thanks for donating their time on a holiday weekend.

Auxiliary Honors 15 Members at February Meeting

The February meeting afforded us the opportunity to honor fifteen of our members for their twenty-five year membership and participation in the PCMSA. Guest speaker Dr. Lane Gerber discussed his research on stress in medical families. Once again, auxiliary members were offered a relevant and thought provoking program. Thanks to Diane Miller for sharing her lovely home for the meeting and to Sonya Hawkins and her committee for a superb lunch.

Delegates Needed for State WSMAA Meeting

Delegates are still needed for the State WSMAA meeting coming up the weekend of May 1, 2 and 3rd at Lake Quinault. Cost is $45.00 a day, double occupancy rooms.

General Membership Meeting, April 27

April 27 is the date of the next general membership meeting to be held at the home of Barrie Mott. In addition to the election of officers, the Finance Committee will present recommendations for philanthropic awards to be voted on by the membership. The program for this meeting will be "Gift of Life: The Organ Donor Program."

continued on next page

Application Deadline for Student Recognition Awards Coming Up

Parents of graduating seniors: the auxiliary will again present the Student Recognition Award in 1984. Applicants must be Pierce County high school seniors who are children of members, past or present, of the Pierce County Medical Society.

Applications are available in counselor's offices in public and private schools throughout the County. Remember applicants names are not known to committee members during the selection process. The award is based on scholarship, leadership and service to school and community. Application deadline is March 23, 1984.

Here's hoping the Irish eyes were smiling on you this month!

—*Janet Fry*

MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

DIANE L. COMBS, MD, *General & Internal Medicine.* Born in Moscow, ID, 3/16/49; University of Autonoma de Guadalajara, Jalisco, Mexico, 1975; internship, Internal Medicine, New Jersey College of Medicine, 6/76-6/77; residency, Family Practice, Mountainside Hospital, Montclair, New Jersey, 7/77-7/79 and Internal Medicine residency, Emanuel Hospital, Portland, OR, 7/79-6/80; graduate TX, 7/80-6/81. Washington State License, 1983. Dr. Combs is currently practicing at Familycare Medicenter, Tacoma/Gig Harbor.

ANDREW D. LOOMIS, MD, *Family Practice.* Born in Tacoma, WA, 5/21/55; University of Washington School of Medicine, Seattle, WA, 1981; internship, Tacoma Family Medicine, 7/81-6/82; residency, Tacoma Family Medicine, 7/82-present. Washington State License, 1982.

KEVIN M. KILEY, MD, *Family Practice.* Born in Chicago, IL, 6/8/55; Wayne State University School of Medicine, Detroit, MI, 1981; internship, Family Practice, Madigan Army Medical Center, Tacoma, WA, 7/81-6/82; residency, Family Practice, 7/82-present. Washington State License, 1982. Dr. Kiley is also the volunteer director of St. Leo's Neighborhood Clinic, Tacoma.

PAUL N. SEWARD, MD, *Pediatrics/ Emergency Medicine.* Born 6/14/43. Harvard Medical School, Boston, MA, 1968; internship, UC Medical Center, San Francisco, 6/68-6/69; residency, UC Medical Center, San Francisco, Pediatrics, 7/69-7/70, and San Francisco General Hospital, San Francisco, Family Practice, 7/73-7/74; graduate training, fellowship in Ambulatory Pediatrics, 9/72-6/73. Washington State License pending. Dr. Seward is currently practicing at Mary Bridge Children's Health Center.

CLASSIFIED

For sale–Two, 8-month-old exam tables. 272-3520, Dr. Holm.

Space for Lease–Professional complex in University Place. Two suites available, 990 sq. ft. and 1324 sq. ft. Rent is $9.00 per foot, includes electricity. Call Bud Harris, 564-6341.

Medical Building for Sale in the Sea-Tac Medical Center, Federal Way. 2,079 sq. ft., includes 3 exam rooms, lab and physicians' office with private entry. Room to expand in daylight, lower level. $195,000. Contact Mike Miller, 244-5706 or 284-7343 (evenings). Portal West Realty.

Plaza 19 Professional Center: Beautiful, new office space for lease near Allenmore. Interiors designed to suit your needs. A unique office location in a park like setting. Call 752-6622.

Lakefront—Prestigious Home for the professional family. Professionally landscaped gardens complete with oriental bridge, pools and teahouse on 100 ft. frontage on Lake Steilacoom. $285,000. Call Micki Boyle, 584-1600 or 582-6047, Lakewood Villa Realty.

Washington: Expanding Physician-Owned Emergency Group has opening for full-time career oriented emergency physicians in South Central Washington. Excellent benefits, including malpractice, disability, health insurance, profit sharing, etc. Flexible work schedules. Excellent working and living conditions. Contact Donald Kougl, MD (307) 234-4795, or send C.V. to EMP, P.C., P.O. Box 3398, Caspar, WY 82602-3398.

Planning an Open House–Professional organizers.Invitation, food and beverage, hostessing, clean-up. FREE estimates. SUNSHINE VENTURES, 759-9354. Kari Stackpole, Suzanne Jordan.

Plant Medical Director–Physician with experience or interest in occupational medicine, to direct preventitive health and medical program for an integrated facility, containing both wood products manufacturing and pulp paper operations. Total employment, including nearby satellite facilities in supporting woods operation, is 4,300. An on site clinic is staffed with two occupational nurses and an industrial hygienist. Excellent salary and benefits. Regular hours. Interested physicians send vita to James L. Goodman, Region Personnel Manager, Weyerhaeuser Company, P.O. Box 188, Longview, WA 98632.

For Sale: Leather couch, traditional, executive look—chocolate brown with brass studs. Excellent condition. $500 firm. 848-3057.

Wanted: Office furniture and equipment for family practice. Call Dr. Young, 581-2038.

For Sale–Active solo Family Practice in major medical center adjacent to hospital in Tacoma, WA. Price is negotiable, and includes leasehold improvements, fixtures, medical/office equipment and supplies, and could also include the accounts receivable for instant cash flow. 2,000 active charts. Contact P.O. Box 110577, Tacoma, WA 98411-0577.

Part-Time or Full-Time Physician needed to share office space in pleasant rural setting in Eastern Pierce County. Please contact Christine Jacobs, Lake Tapps Family Medicine, 862-8001.

Lease or Sale: Medical Office Building #5, Tacoma Medical Center. Family practitioner retired; reasonable terms. 752-5206.

GP Retiring–Walk in and take over. Reasonable terms. Beautiful Mt. Vernon, 3 blocks from hospital. 428-2626, day or night.

Planned Medical Building–112th near 94th, middle of valuable South Hill professional area, Puyallup. Build to suit. Call Clyde Martin, 845-9284.

We Make House Calls

When a client has been referred to us by a physician, one of our first steps may be to make a house call. These home visits help us gain a more complete understanding of the client, sometimes giving us insight into possible problem areas. And we also listen to you.

As Washington's oldest and largest independent vocational rehabilitation firm, we have five fully staffed and conveniently located offices to serve you. Each is staffed with professionals trained to make skilled assessments and to carry out rehabilitation programs. Each office is computer equipped, so we can tap into job bank information when it's time to help the client with work or training. Of course all fees are insurer paid.

If you'd like to refer a case for evaluation or job placement/training, or for any of our other services, such as vocational and psychological testing, job modification and work tolerance assessment, please call our Tacoma office: REHABCO/Vocational Services Northwest Inc., 738 Broadway, Tacoma, WA 98402, (206) 383-3735.

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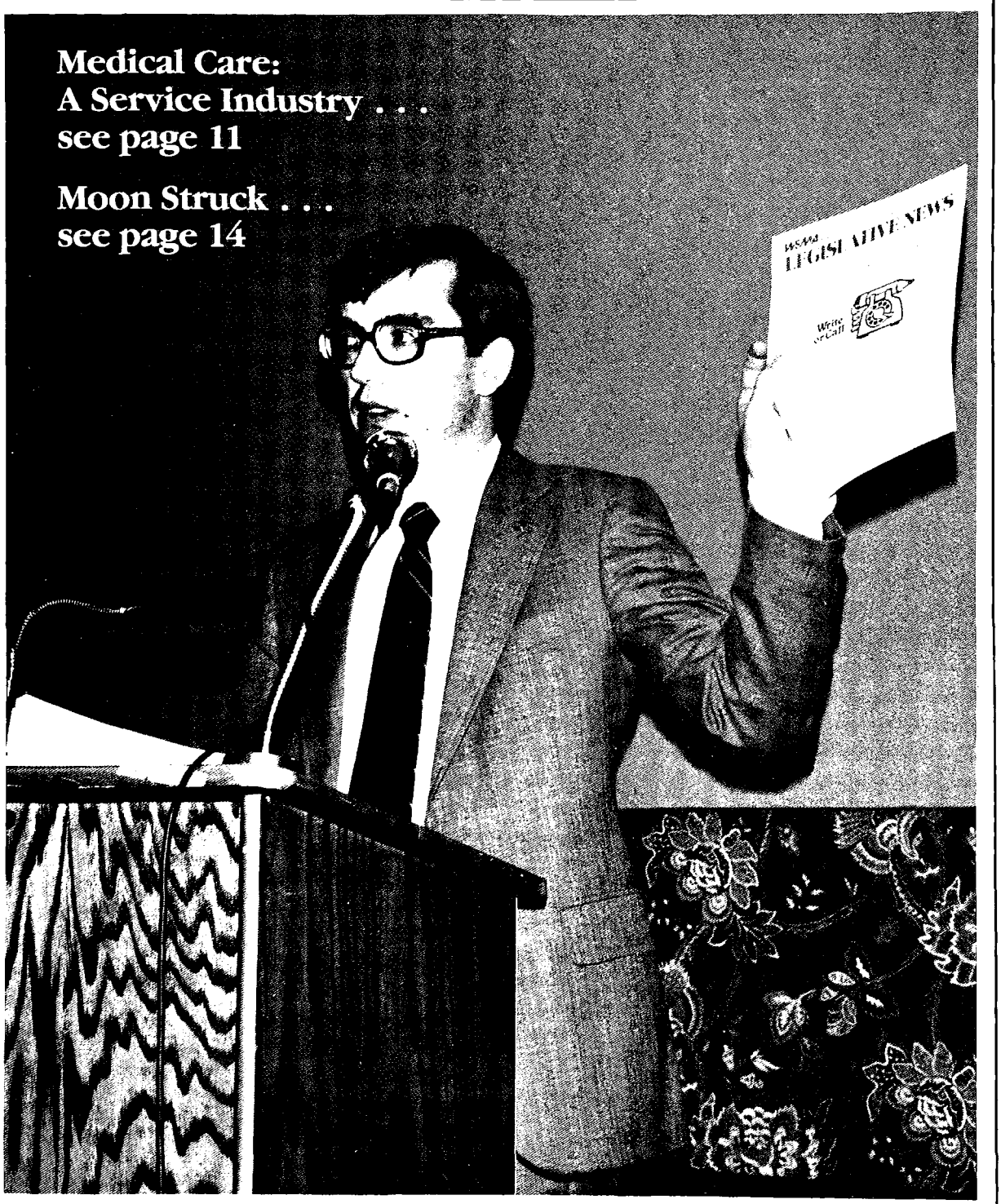
The Bulletin
MEDICAL SOCIETY OF PIERCE COUNTY

April, 1984



**Medical Care:
A Service Industry . . .
see page 11**

**Moon Struck . . .
see page 14**

FINALLY, A MEDICAL COMPUTER SYSTEM THAT ADJUSTS TO YOUR OFFICE. NOT VICE VERSA.

Some medical computer systems act like they never saw a doctor's office before.

First they make your staff learn a new format for posting information. Which can upset your office staff without really improving the way you get your billing out.

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The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

cover photo by Linda Carras
Vice President Dr. Richard Hawkins, March 13 General Membership Meeting. See Local News Briefs for story.

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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President's Page

FEDERAL LEGISLATION AND THE CHANGING FACE OF MEDICINE

The interrelationship between government and the health care industry is an intriguing one, often adversarial in nature. In this column, I outline several issues which are of major concern to physicians and hospitals in this regard.

The first is federal legislation. As I review bills pending in the U.S. Congress, particularly those in the Medicare and Medicaid arenas, I become even more convinced that hospitals and hospital staffs must organize in some kind of corporate arrangement that will give us increased operative clout against what is often a unilateral and/or retroactive "changing of the rules" by the government.

I am concerned, specifically, with two current pieces of legislation: the Kennedy-Gephardt Bill and the Rostenkowski Amendment to HR-4170. The Kennedy-Gephardt Bill, if enacted, will impact physicians, of course. But what it does to hospitals is much worse, especially in the West. It protects the higher cost states with long lengths of stay by using historical state cost averages, rather than national averages, thus locking in low cost states like Washington to a much lower base cost per discharge.

The "historical admission base" provision of the bill is intended as another cost-containment measure. If hospitals, for whatever reason, begin to admit more patients than their "historical averages," they will be reimbursed only at approximately 40¢ on the dollar for admissions beyond the historical base.

Under the Rostenkowski Amendment, hospitals would be allowed to participate in Medicare programs only if *all* physicians on the medical staff enter into agreements to treat all Medicare inpatients on a prescribed, assigned-fee basis. This price-fixing measure also requires physicians to accept Medicare assignments for all services provided in the hospitals to Medicare patients, at the risk of losing staff privileges.

These two bills, if passed into law, would have much to do not only with our mode of practice, but also with our income. In addition, they would pose a great financial threat to our hospitals. This haphazard approach to cost-containment by the federal government has many hospital staffs worried, with good cause. Even under current conditions, it has been projected that at least 1,000 hospitals in the United States will close their doors in 1984 due to lack of funds.

Legislative efforts such as these, while continuing to promise virtually unlimited access to all, do not address "state of the art" questions regarding methods of practice or new technology. A prime example is the DRG system, which does not allow for increased cost advances such as streptokinase therapy.

Another issue in which government impacts our profession and our financial health is that of comparable worth. While comparable worth *per se* is not a major question for non-governmental hospitals, it is a question when one thinks of pay parity for health care "rank and file" workers.

As you know, salaries often are not equal to comparable positions, skilled or unskilled, outside of health care. We have been losing good people from our industry because of this fact for years. Our ability to remedy the situation rapidly is non-existent amid the current regulatory and political climate.

Finally, a few words about competition within our industry. While such competition may have some positive spin-offs, it also brings with it problems. The public's image of health care providers often is reduced when they see hospitals scrambling after patients through media advertising or through "this week's deal" in whomever's emergency room.

In the effort to maintain financial stability, there is the potential that hospitals will cut back on their free care. They may try to shuffle the lower-paying DRGs to other hospitals. Indeed, some of this is already happening. Competition among and between physicians and hospitals may heighten distrust to the point where appropriate management of health care delivery may well end up totally outside the system.

Again, I refer to one of my opening remarks about the need for an operative corporate structuring of medical staffs and hospitals. While business coalitions, PPOs, HMO expansion, etc., may play an increasingly positive role in the long run, knee-jerk reactions by providers may do a lot of damage in the interim.

Increasing concern about the future of health care is affecting the reactions of all providers: hospitals, MDs and other licensed practitioners. Problems of health care providers, caused by consumers cutting back on MD visits and hospital admissions over the past two years, heighten that concern, in some cases to the point of paranoia. Even a return to relatively low unemployment and increased numbers of insured consumers probably will not bring back business as it used to be, given consumers' overall concern about costs.

All of these financial considerations lead to the potential danger of medical care which is of lesser quality. Our basic mission, therefore, is compromised.

There are, of course, many other facets to the interrelationship between and among government, hospitals and physicians at present. Many are troublesome. Nevertheless, let each of us remember that our primary mission, curing the ill, is still our basic business. Changes in our profession are imminent—and they will be made. Let us, each in our own way, lend constructive criticism to these changes. Let us maintain and, where necessary, restore the image of a respected medical profession.

—JPD

Local News Briefs

Medical Society Members Serve on Medical Advisory Committee Established for Tacoma-Pierce County Adult Health Program

The Medical Society of Pierce County recently assisted the Tacoma-Pierce County Health Department formalize a Medical Advisory Committee for its Adult Health Program. Physicians serving on this committee are: Drs. Harry Lawson, Richard Gilbert, Charles Weatherby, Emily Koeniger, David Munoz and Richard Waltman.

Health Department's Well Adult Clinic Conducts Pilot Study

The Health Department's Well Adult Clinic Program will be conducting a pilot study during April. The pilot study, in cooperation with the American Heart Association, is designed to increase public and professional awareness of candidates for stroke in order that early medical intervention might prevent strokes.

All Well Adult Clinic participants who have their blood pressure monitored will be screened for any history of alteration in speech, alteration in vision in one or both eyes and any weakness or numbness affecting face, arms or legs.

If the client answers yes to any of these symptoms, a letter will be given to the client to take to his physician for his information.

Study results will be returned to the American Heart Association and compiled to help develop an appropriate screening and education program for early detection of stroke warnings. If you desire information about this, contact the Adult Health Program, 591-6480.

Provisional Members Elected to Membership

Congratulations are extended to the following provisional members who were elected to membership in the Medical Society of Pierce County at the March Board of Trustees Meeting: Drs. Michael G. Blackburn, Dennis D. Drouillard, Betsy L. Fine, Robert U. Finnerty, Richard M. Oliver, Louis A. Roser and Alvin J. Wright.

Tacoma-Pierce County Senior Nutrition Program Serves over 149,000 Meals

The Tacoma-Pierce County Senior Nutrition Program serves hot, nutritious meals in 14 locations at noon throughout Tacoma-Pierce County. Persons 60-years old and their spouses, regardless of age, are eligible. In 1983, 149,650 meals were served to 5,102 different seniors.

The Home Delivered Meal Program or "Meals on Wheels," provides meals to persons 60-years old or older who are home bound due to illness or disability, unable to cook or shop for themselves, or have no assistance in shopping.

Clients select from a menu of assorted frozen dinners and breakfasts. Nutrition, education and diet counseling are provided by registered dieticians to seniors who need to follow a modified diet as part of a physician's treatment plan.

It is important for physicians and other medical professionals to know that these services are available to seniors. For additional information you may call 572-4830. The program is sponsored by the Tacoma-Pierce County Chapter of the American Red Cross.

Dear Physicians,

In order to update the Speakers' Bureau list for the Medical Society of Pierce County, we'd appreciate your cooperation. Do you want to be included on the speakers' list?

Yes _____ No _____

If so, what topics would you be interested in discussing (medical or non-medical):

_____

_____

_____

_____

Office phone number _____

Please return this form to: Speaker's Bureau Office
Medical Society of Pierce County
705 S. 9th, Suite 205
Tacoma, WA 98405

IN MEMORIUM

Medical Society member Dr. J. Robert Brooke died March 2, 1984 in Tacoma, Washington. He was 74-years old. Memorial services were held March 6 at the Tacoma Elks Lodge.

A Pacific Northwest native, born in Seattle, October 5, 1910, Dr. Brooke began his practice as a General Practitioner in Pierce County in 1940.

Local News Briefs, continued from page 5

Photo by Linda Carras

Washington State Medical Association President Dr. Richard F. Ambur addressing the March 13 General Membership Meeting. Dr. Ambur urges the medical community to get involved in the political process.

COGNITIVE VS PROCEDURAL FEE REIMBURSEMENT THEME FOR MAY 8 GENERAL MEMBERSHIP MEETING

The long-time, simmering issue of cognitive vs. procedural fee reimbursement will be the theme of the May 8 General Membership Meeting. Mark your calendars now. See page 23 of this month's *Bulletin* for your registration form.

Dr. Eugene Ograd, II, MD, JD, member of the American Board of Internal Medicine and fellow, American College of Legal Medicine, will address the membership. Dr. Ograd co-chairs the Cognitive Services Ad Hoc Task Force for the American Society of Internal Medicine. Plan to attend.

Editor's Note: The date on the registration form for the May 8 General Membership Meeting you received in the mail was printed in error. The date should read May 8 not March 13.

ORGANIZED MEDICINE IN '84

Washington State Medical Association President Dr. Richard Ambur addressed the March 13 General Membership Meeting held at the Executive Inn in Fife.

Dr. Ambur stressed the importance of physicians involvement in the political process if we are to maintain our ability to "take care of the people."

Numerating the tremendous progress physicians have witnessed in the last two decades in the health care field, he asked those present if "this is something we want to come to an end?"

He said that it was imperative for every physician to join and participate in the federation of medicine and the political action committees.

Photo by Linda Carras

Drs. David Law, a new member of the Society, and Joseph Kraemer, a long standing member of the Society, enjoy themselves at the membership meeting.

Photo by Linda Carras

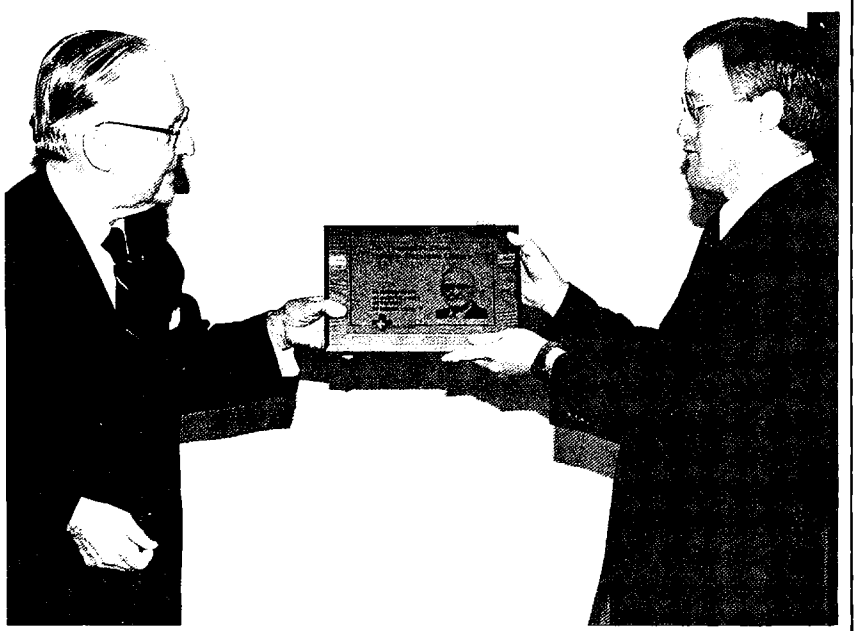
Dr. Tom Clark (left), long time active member in the Medical Society discussed issues with Dr. David Munoz, a recent applicant for membership into the Society at the General Membership Meeting.

Need a Referral?

During the month of February, the Society's office staff answered approximately 300 calls requesting assistance in finding a doctor. Nearly 61% of these prospective patients had insurance and the ability to pay full fee.

Are you on the Referral List? (It is quite small.) Are you missing an opportunity to expand your practice? Call the Society's office to make certain you are on the Referral List.

GOOD SAMARITAN HOSPITAL'S NEW HEALTH SERVICES LIBRARY NAMED IN HONOR OF DR. THOMAS CLARK



Dr. William Marsh, president of the Good Samaritan Hospital medical staff, presents Dr. Clark with a commerative plaque.

The Dr. Thomas H. Clark Health Services Library was dedicated March 16.

The new facility was named in Dr. Clark's honor because of his interest and involvement in medicine, particularly health education, over the past 40 years. Dr. Clark maintained a private medical practice in Sumner from 1946 to 1975.

Retired from active primary care practice, Dr. Clark is a geriatric consultant and medical director to nursing homes in the area.

He is active in the Medical Society of Pierce County, the Washington State Medical Association, Pierce County Health Department and serves on the Good Samaritan Hospital Education Committee. He served as President of the Washington Academy of Family Physicians in 1982-83.

Born in Roslyn, Washington, Dr. Clark received his graduate and undergraduate degrees from the University of Washington. He received his doctorate of medicine from the University of Oregon. After two years internship at King County Hospital/Harborview, Dr. Clark served in the U.S. Army ground forces. He began his private practice after discharge from Military Service in Sumner with Dr. Charles Denzler and Dr. James Duffy.

HOSPITAL ADMISSIONS DECLINING

The March 6, 1984 edition of the Tacoma News Tribune published the following Associated Press article which was the result of studies from the American Hospital Association.

CHICAGO (AP) — Hospital admissions are declining and stays are shortening because more people are unemployed, more patients have to pay a higher percentage of their medical bills themselves and there are more alternatives to hospital care, an economist said.

"There are a number of reasons — we're not sure which one is dominating," said David Dolkart, manager of health economics studies for the American Hospital Association.

Admissions dropped about 88,000 in the first 11 months of 1983 compared with the same period in 1982, from 34,953,000 to 34,865,000, he said. Although admissions increased among people over 65, they dropped 2.6 percent for people under 65, he said.

Meanwhile, the average length of stay dropped 2.8 percent during the same period, from 7.2 days to 7.0, Dolkhart said.

"It's a long-term decline going back a number of years," Dolkhart said.

He listed these contributing factors:

- A slowly dropping unemployment rate. Workers just back on the job may be covered by less-liberal benefit plans and may opt for fewer elective procedures.
- More deductible and co-payment benefit plans. Patients may have to pay a greater part of the bills for their medical care out of their own pockets instead of relying on insurance.
- Medicaid program restrictions. Several states have tightened rules on health benefits to the poor.
- Growth in alternatives to in-patient care. Patients may be relying more on free-standing clinics and free-standing emergency centers.

ADVERTISEMENTS GAINING SUPPORT AMONG DOCTORS

Physicians advertising has been noticed by 28% of Americans, according to a Public Opinion Poll, prepared by the AMA Department of Survey and Opinion Research.

Awareness of physician advertising is highest among high income earners (39%) and lowest among those who are 65 years of age and older (17%).

The public's awareness of advertising has not increased in the last year. Results for August 1983, were the same as for August 1982.

The percentage of physicians who supported advertisement of fees in newspapers or on television or radio have more than doubled since 1978.

In that year, 8% of physician respondence supported this concept of listing fees in the media.

continued on page 8

Advertising Gaining Support Among Doctors, continued from page 7

In this year's poll, 17% supported fee advertising, according to an AMA Survey of Physicians Opinions on health care issues.

The overwhelming proportion of physicians, however, continues to reject listing fees in the media. A solid majority do not favor listing fees in the local area directories. (Information for this News Brief was taken from: *American Medical News*).

PHYSICIAN—HOSPITAL RELATIONSHIP STUDIED

MSPC President Dr. James Duffy has appointed Dr. Ralph Johnson to serve as chairman of the new Medical Society-Hospital Project Steering Committee. The committee's charge is to determine the feasibility of developing a medical staff organization so that physicians and hospitals may work together in the new competitive era on a co-equal basis.

The committee was created as a result of a Resolution being adopted by the September 1983 meeting of the WSMA House of Delegates. The Resolution sponsored by MSPC past president Dr. Lloyd Elmer was one of several submitted to establish programs assisting physicians in maintaining successful practices in the 1980s.

The Resolution reads in part:

"Whereas, existing hospital medical staff structures and relationships place the physician staff in a subservient role relative to its relationship with hospital corporations, thus making it desirable to establish a new mechanism for physicians to work with hospitals more equitably and effectively; and

Whereas, the WSMA, in supporting its members' needs to work with hospitals, may find it in its own best interest to create a statewide corporation that would have as its primary purpose the provision of support services to individual medical staff corporations, independent of the traditional medical staff organization of hospitals;

Whereas, it is in the best interest of patients for physicians and hospitals to work together to maintain high quality, accessible health care for the benefit of the community. . ."

The Committee will be reviewing the model program developed by the Hennepin County Medical Society in Minneapolis, Minnesota. Medical staffs and their hospitals work together as equal partners to face the competitive market pressures the community will be facing in the 80s.

The medical staff-hospital (MESH) joint venture is equally owned by a hospital and the members of its medical staff. The medical staffs and their hospitals can work together as equal partners.

The joint venture will provide physicians and hospitals with an appropriate organizational structure for responding to the powerful forces shaping the health care system, such as prospective payment, industrialized medicine, competitive ambulatory care network, shrinking patient bases and soaring health care costs. (From: Joint Venture Project, Hennepin County Medical Society.)

Other members of the Committee are: Drs. Duffy, Bischoff, Elmer, Houtz, J. McGowen, Robson, Spaulding and Symonds. We will keep you appraised of the Committee's activities in coming issues of *The Bulletin*.

A SYMPOSIUM ON SURGICAL ONCOLOGY

53rd Annual Meeting - Tacoma Surgical Club

Friday April 27	Morning Afternoon	9:00 A.M. to Noon 1:30 to 4:30 P.M.	*Dissections/Papers/Displays* *Papers Presented*
Saturday April 28	Morning only	9:00 to 11:50 A.M.	*Papers Presented*

OPEN TO ALL INTERESTED PHYSICIANS
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All presentations at: University of Puget Sound
Thompson Hall
1500 North Union, Tacoma

FUTURE TRENDS IN PEDIATRICS

12th Annual Day of Pediatrics

Sponsored by: Multicare Medical Center
Mary Bridge Children's Health Center

Saturday
April 28 8:45 A.M. to 4:05 P.M.
Jackson Hall - Tacoma General Hospital Education Center

- *The Changing Pediatric Role*
- *The Medically Fragile Child*
- *Childhood Malignancies*
- *Hospice & The Child*
- *Childhood Tomorrow*
- *Pediatric Critical Care*
- *Pediatric Emergency Care*

CARDIOVASCULAR DISEASE REVIEW

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Progress Notes
A Report from Membership Benefits, Inc.

MANAGING THE BUSINESS SIDE OF YOUR PRACTICE

Dolores Lunstrum, author of the following article, is owner of Management Resources, a service endorsed by Membership Benefits, Inc.

When I was raising my children, there was a phrase that became very familiar . . . "but Mother, you have to let me go! EVERYONE's going!" or, "I have to have one like that, EVERYONE else does!" or, "I just can't do that, NO ONE else does!"

It didn't seem to matter if we were discussing the upcoming school party . . . the wearing of a certain logo over the backside of your jeans . . . or taking their younger sister to the school basketball game. The important consideration was the fact that they had to be just like "everyone else."

Often now I am consulted by a physician to discuss ways of improving his practice. We cover management reports, personnel policies, interoffice relations . . . and then practice building. As the term "advertising" is used, the concern becomes, "Will my peers accept this action."

Many times the final decision is, "I think I will wait a year or so, and see what everyone else is doing." The time is rapidly approaching when the private practitioner will realize that "Everyone is doing it," and, although there will always be those who cling to the past, medical marketing is a part of our existence, both present and future, whether we like it or not.

According to the American Medical Association there is a difference between "advertising" . . . "hard-sell advertising" . . . and "marketing."

In the past few years marketing has become not only acceptable, but encouraged by AMA. The Michigan State Judicial Council has offered some guidelines for marketing. They recommend that you provide the following:

- General information, such as name, title, office address, telephone numbers, answering service, office hours, etc.

- Professional information such as degrees earned, board certification, areas of specialization, limitation of professional practice, professional affiliation, hospital affiliations and foreign language competence of physician and staff.

- Fee information, for routine professional services, notification that fees may be adjusted for unforeseen circumstances and third party payers that are recognized.

Advertising that is considered inappropriate is that which includes:

- Testimonials and/or anecdotal reports of success by the practitioner, or claims of superior quality of care to entice the public.

- Fee comparisons with other practitioners licensed under the Medical Practice Act.

Within the terms of this voluntary code there is wide latitude to advertise.

"Cheshire-Puss," she began, rather timidly . . . "Would you tell me, please, which way I ought to go from here?" "That depends a good deal on where you want to get to," said the Cat. "I don't much care where," said Alice. "Then it doesn't matter which way you go," said the Cat.

—LEWIS CARROLL

STEP II in our marketing steps is "Formulation of realistic objectives." If you don't know where you want to be in your practice, then, like Alice, your efforts will be wasted.

Webster defines "Goal" as "the end toward which effort is directed."

"Objectives" are the specific, measurable ways by which you intend to realize your goals. You will first want to establish a long term goal, and then compile a series of objectives to help you reach that goal.

Goals and objectives should be hierarchical, that is move from the general to the specific, from your most basic goals to the various subsidiary ways in which you intend to reach these goals.

For instance your "goal" may be "to provide the best and most convenient medical care for your patients." Your objectives could be (1) to increase your ambulatory surgical care by 15% for each of the next three years, and (2) to decrease the waiting time of your patients in the office by 10 minutes per patient in each of the next three months.

Objectives are not supposed to represent exercises in wishful thinking but rather the results of appropriately chosen goals for the organization given its environmental opportunities and restraints, according to Philip Kotler, in "Marketing for Nonprofit Organizations."

As far as possible, all objectives should be quantitatively verifiable within a deliniated time frame. Your objective might be "to increase utilization of in-office ultrasound equipment by 10% in the next 6 months." Review statements of practice goals often. They should serve as the standards against which to assess the success and appropriateness of your marketing activities.

As your long-term goals are defined and your objectives formed, these become the base upon which your marketing plan is developed. Promote those services which you intend to expand; plan your strategy to reach those persons that will utilize these services, and use those advertising mediums which will have a positive affect on the type of people you are seeking.

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MEDICAL CARE: A SERVICE INDUSTRY?

By William A. Gruber, MD

The following article is reprinted with permission from the King County Medical Society Bulletin. Its author, Dr. William Gruber, is a member of the King County Medical Society.

The nature of medical care, as perceived by government, hospitals, employers, consumers, the courts, and by physicians themselves, is changing rapidly. There is considerable evidence to suggest that medicine is being transformed from a professional into a service industry at an ever accelerating rate. It is worthwhile to examine some of these perceptions, the forces behind them, and from these project possible consequences.

The most apparent change has been the recent institution by the Federal Government of reimbursement according to Diagnostic Related Groups (DRG's), and the institution of competitive bidding for health services on the state level in California. On the surface these governmental limits on reimbursement are intended primarily as cost control measures. There is, however, widespread concern that these measures will have unintended consequences, far beyond cost control alone.

One such concern is the subjugation of individualized needs. For many years federal and state governments have had difficulty in fitting the delivery of health care into conventional economic models in order to predict and control cost. Many reasons for this have been cited, but foremost among them has been the fact that doctor's decisions about how to treat, when to hospitalize and what to charge are made independently of conventional market forces, in part because of the variability and unpredictability of delivering health care to different individuals. DRG's eliminate the difficulty in achieving conformity to economic models by eliminating the problem of variability and uncertainty, and instead impose uniformity by fiat. The benefit to the government is that it has a commodity which can be more readily subjected to economic predictions and models. The major concern, of course, is whether the individuality of patient care can be reduced to specific commodity items.

A second, and perhaps graver implication of the change in governmental perception of medicine, as manifested by DRGs, is the probability for limiting health care. Since the early 60's health care reimbursement has been based upon two fundamental principles which reflected basic societal values. These were (1) that everyone had a right to health care, and (2) that everything possible should be done to preserve the life of an individual and restore health, regardless of cost. These principles, although appealing, had unintended consequences. They implied open-ended reimbursement, for everyone, without limit. The imposition of diagnostic related groups not only implies that health care will be packaged into discrete groups, but also that reimbursement and hence utilization of these groups will be limited.

Thus in a very fundamental way governments at several levels appear to be repudiating previous basic social ideals and instead imply that in some yet to be defined way health care will have to be limited. Is health care a limited commodity to be parceled out? The answers are not yet in. If such governmental assertions do, in fact, represent our society's new values, then perception of medicine as a commodity is pervasive.

Hospitals, in their response to government limits on reimbursement, have begun a series of counterpoints. From the hospital's point of view they are maneuvers designed only to ensure financial survival. As with government measures, however, such moves may have unintended consequences which further reduce medicine to a series of product lines.

Lest the term "product lines" seems offensive when applied to human illnesses, that is in fact the response to DRGs and the term is now openly used in hospital marketing pamphlets. Hospitals, in order to survive, must determine diagnostic groups that can be treated in their facility at a profit as opposed to those groups which will be reimbursed at a loss. Administrators will be under increasing pressures to determine which product lines to retain and which to eliminate, possibly independent of patient needs within their community.

Government, the courts and the health care delivery system are pushing medicine relentlessly toward a service industry.

Advertising is a second possible hospital countermove. Marketing, in the sense of familiarizing the community with services available, has been promoted by hospitals for some time. The presence of profitable product lines versus unprofitable ones, however, creates a new and different marketing need, that of pushing or promoting specific services which the hospital can provide at a profit so as to ensure its survival. Under such pressure it is very possible to move from the area of community information to that of advertising as practiced in the business community. Such pressures are increasingly recognized within hospital administrations, resulting in marketing departments of increasing prominence. The conflicts they will engender have yet to be resolved.

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A third hospital countermove is that of restructuring the hospital corporation so as to allow profits. Profits at one time did not seem appropriate in medical care. They are now. "For Profit" hospital corporations are expanding. Profits are also emerging within previously conventional "nonprofit" hospitals in the form of "for profit" subsidiaries which can bill and benefit from diagnostic related groups directly so as to ensure maximum reimbursement.

The fourth countermove has perhaps the most significant implication for the medical practitioner: the aggregation of medical delivery systems into larger groups. The medical profession was once frequently described as "the last of the cottage industries." Such may no longer be the case. Individual practitioners could exist as long as medical care was individualized and did not conform to economic models. If DRGs can succeed in conforming medical care to economic models, then the classic laws of economics of scale will make it highly unlikely that individual practitioners can successfully compete. At many levels the net result of the imposition of diagnostic related groups will be the aggregation of health care providers, whether hospitals or practitioners, into larger groups in order to protect a market and/or realize economies of scale. This is most apparent in national hospital chains which have successfully maintained viability of smaller hospitals by subsidizing them with corporate support divisions. Locally, aggregation in order to protect a market is most readily apparent in proliferation of plans to coalesce into IPAs, PPOs and HMOs. If economic forces cause the coalescence of practitioners into large groups there will be increasing pressure toward conformity of medical care in order to control and predict costs.

We have no way, as yet, of assessing whether conformity to economic constraints in practice is compatible with excellence in serving patients. There is widespread concern that physicians who are faced with individualized needs of patients will increasingly be in conflict with hospital administrators bent on controlling costs. All of the countermeasures of the hospitals may work only as intended, that is, as stringent business measures. They may, however, have the unintended consequence of moving health care delivery away from a profession meeting individual needs, and toward a service industry responsive primarily to rules of the market place.

Just as hospitals have responded to governmental changes, the private business sector has responded to economic changes by forming employer coalitions negotiating for health care services. As with government, this trend arose from the need for limits. During economic expansion business could afford ever increasing health care benefits. During the recession, however, open-ended costs of this type threatened survival of many corporations. The era of unrestrained pass-along to their party payors was now no longer possible. Thus the coalitions, in a larger sense, represent a limit on health care as a function of the economic climate.

Such coalitions are not new. They were common in the early 1900s, when railroads, shipping and other large businesses had their own hospitals, with physicians under salary. They were attacked because they limited patient mobility and freedom of choice. They disappeared in the face of increased emphasis on individual doctor-patient relationships. Now, however, we are watching a de-emphasis of such relationships. Indeed, the terms "patient" and "doctor" have commonly been replaced by the terms "health care consumer" and "health care provider." If medical care can be reduced to only a service, a commodity exchanged between providers and consumers, then it is likely that the assignment of health care by employer coalitions to specific provider groups will not impinge upon the needs of individuals, because the doctor-patient relationship will have ceased to be a consideration.

Is getting one's ankle fixed the same as getting one's car lubricated?

It may be that society, the health care consumer, is quite content to see the traditional doctor-patient relationship erode to the status of provider-consumer. Patients routinely have to deal with a bewildering myriad of physicians, numerous consultants, various house officers, and a variety of doctors covering on weekends or holidays. Within large clinics or HMO systems random assignment to the physician of the day may be the routine way of obtaining medical care. This has probably reached its ultimate form in the rise of freestanding emergency care centers which are operated entirely on a non-personal basis. It is probably no accident that a recent emergency clinic opened in Kenmore in the same building as a "60 Minute" tune up shop. The issue here is not whether such centers provide good care, but rather whether society has come to perceive medical care as simply a service one walks in and purchases. Is getting one's ankle fixed the same as getting one's car lubricated? At one time that would have been a ludicrous question, but the success of such centers suggests that such is no longer the case.

A further manifestation of this shift in society's perception of the nature of health care is apparent if one looks closely at the malpractice issue. Obviously the problem has many causes. One is worth mentioning here because it reflects not poor practice, but rather changing social perceptions of medicine as reflected in court decisions.

In past legal perceptions, the doctor was felt to be entrusted with the care of his patients. Both the patient and society as a whole had come to require certain levels of care. Legally this fell within a fiduciary obligation. A common example today of fiduciary obligation is the management of a pension fund on behalf of others. All that needs to be shown is that reasonable care was exercised and benefit was intended. The inherent risks in investments are acknowledged; thus it is not a requirement that an investment make money for a fund, and indeed, an investment may lose disastrously without liability being found if "normal" prudence had been exercised, but not necessarily results, that physicians dealt with their patients.

There is considerable evidence to suggest that one of the fundamental underpinnings of the current malpractice problems is not malpractice per se (indeed there are statistics which suggest that excellent physicians who take on difficult cases are sued more commonly than "demonstrably inept" physicians), but rather the gradual but relentless transition by the courts and possibly by the society they represent away from a fiduciary trust relationship of the doctor

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to his patient and toward a liability based on consumer contract law. There is increasing emphasis on specific services provided, and results achieved. The liabilities of informed consent are conspicuously similar to the liabilities of disclosure in packaging. The recent cases involving wrongful life and wrongful death have made headlines with respect to their awards, but are more significant in that they continue the trend towards increasing emphasis on results. We are approaching the era, especially in obstetrics, of implied product warranty. There are numerous cases which have resulted in successful action against a physician, not because of violation of community standards of care, but simply because of a bad result. Indeed, although the harassment of a trial is still a burden to any physician, the stigma of malpractice, in the sense of ineptness, is rapidly diminishing and the liability, along with its increasing premiums, is becoming perceived as simply another cost of doing business and of marketing a risky commodity.

Apart from changing perceptions of medicine by society, perhaps most troubling may be the gradual change in the perception of the profession by physicians themselves.

The medical profession has not always enjoyed the esteem or income it currently does. Before the 1900s practitioners in the United States were not particularly well thought of, or reimbursed. Even today, in other societies, a physician may be simply a technocrat. The remarkable status of physicians in this country began early in this century as a result of the rise of scientific knowledge and the strict standards as to who was sufficiently trained to practice such knowledge. Lewis Thomas, in his book *The Youngest Science*, points out that physicians in the 1930's were held in high esteem despite the fact that their knowledge was limited primarily to diagnosis. They were incapable of intervening in the course of most diseases. The patient-physician relationship at that time was one of personal interaction, consisting of diagnosis, prognosis, support and advice. Beginning in the 1930s, with the rise of antibiotics and the triumph over infectious diseases, physicians could intervene with progressively greater success. We could do more and more. A transition began, away from a relationship based on personal interaction, and toward one based on services provided. We now have smaller and smaller subspecialties which provide better and better services, but with progressively less patient interaction.

A re-emphasis on family physicians sought to redress this problem, but it became clear that one could do so only in the face of economic conflict. The importance of providing specific services had become so entrenched that doctors who do procedures get paid considerably more than doctors who diagnose, advise and support. The issue is not whether such should be the case, but rather that it is. The push toward becoming a service industry rather than a profession has had a major contribution from doctors themselves.

The conflict between medicine as a healing profession and medicine as a livelihood is not new. What is new is the perception by the public of increasing emphasis on the business aspect of medical practice. Seminars stress strict business management of a practice. Payment at the time of service is urged. Credit cards are increasingly accepted. Assignment of Medicare is a recurrent issue. It is only half in jest that some have suggested that *Medical Economics* is now the most widely read medical journal.

There is no intrinsic conflict between sound principles of business management and the quality of care delivered. There is no evidence to suggest that the recent emphasis on such practices in any way impairs the quality of care being delivered. The problem arises from a patient's perception of such measures. It is very difficult for a lay person to accurately assess the quality of care. It is, however, relatively easy for them to assess the nature of billing and collection. The concern that arises is not that strict business practices will impair the quality of care delivered, but that they will be perceived by patients as an ever increasing emphasis on the business aspects of medicine, on the delivery of specific services for specific line item charges, at a time when intangibles such as a personal relationship appear to be declining.

For many years there has been an undercurrent of bewilderment amongst physicians who have conscientiously tried to provide quality medical services and have difficulty in understanding why they have been characterized as money-grubbing fat cats. The problem arises from the difference in perceptions. A recent review of hospital bills has helped to shed considerable light on this. One patient was irate over a $12.00 charge for an ice pack. He didn't know how much Recovery Room time should be charged. He didn't know how much an IV solution should cost. But he knew that for $12.00 he should be able to buy an entire ice chest and take it home with him. The problems arose not from strict business accounting methods and computer listing of line items, which in

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MOON STRUCK

By Marcel Malden, MD

Member of the Medical Society of Pierce County since 1963, Neurologist Dr. Marcel Malden is an avid outdoorsman who knows how to enjoy the Pacific Northwest backpacking, hiking, fishing and, moon watching.

It seems the moon is in my blood. Well, perhaps not in my blood, but certainly in my astrological chart. Born under the zodiac sign of Cancer I am governed by the moon, or so I am told.

There must be something to this story because I have always admired moonlight. I have enjoyed looking at the full moon and have felt peculiarly disturbed by its golden glow.

From my house perched high above the bay I have watched the moon rise. I have marveled at the fact that the early moon, just above the horizon, seems hugh and yellow, and as it travels across the sky it seems to become smaller and brighter.

In its nightly path the moon comes to shine on my desk and still later into my bedroom. I can awaken in the middle of the night and there, beaming at me through the window, is my shiny friend.

Sometimes I feel I could understand why animals may howl at the moon. On other occasions such thoughts appall me.

Since I first slept in the mountains under the starry skies and could see the moon without even having to move out of my sleeping bag, I have always wanted to be in the open on the nights of the full moon. This has been difficult to arrange since my free time did not always coincide with full moon nights. Tied down in the city, I yearned to be high, on an open plateau with a vast, panoramic view.

I succeeded several years ago when I spent a brilliant moonlit night on the summit of Quartz Mountain on Monastash Ridge. I did not sleep much that night. I kept looking at the golden-white outline of Mt. Rainier basking in the eerie light.

A couple of years ago I decided that come what may I was going to make it to a high and lonely spot during a moonlit night in June. It took me some time to decide on the specific spot. I wanted to be able to get there and back by car in a reasonable time. I wanted the hike to be relatively brief, and I wanted to have a trail that was sufficiently comfortable and "smooth" so that I would be able to return with reasonable safety in the darkness.

My first choice was Glacier View, sometimes referred to as Glacier Vista Point. I have visited that spot in the daylight and spent hours sitting on the point of the rock, marveling at the beauty around me. The round trip hiking distance from the trailhead is about six miles. The elevation gain is probably no more than 750 feet. The Copper Creek logging road starts off the Mountain Highway a few hundred feet this side of Copper Creek Lodge.

The chosen day was as clear and sunny as one could wish for. Frenetically I completed my work, loaded my truck and set off. I reached the trailhead in good time, but as luck would have it, the first part of the trail was virtually obliterated by windfall; while I could have struggled through it, the prospects of return with only a flashlight deterred me.

I turned around, returned to the saddle before the trailhead and chose another spot, readily accessible by car. The sun was setting by then and the changing colors with brilliant yellow hues, deep reds and the final pastel shades of pink and blue provided me with a visual feast second to none.

Shortly after the sky became dark, I noticed lights on the northern horizon. After a while I realized with great astonishment that I was witnessing a display of the northern lights, aurora borealis. I have seen such displays previously on my trips to northern Canada, but I have never seen them in this area.

The lights were predominently green and pale blue, but their evanescent movements, delicate surges and changing intensities provided me with a heavenly ballet that went on and on. Around 10:30 I saw the earthy glow on the eastern horizon and soon "my moon" came up.

It was eerie and strangely warm. The shadows were sharp and dark. I was able to see around for miles, to Gobbler's Knob Lookout and beyond to Mt. Rainier. Its heavenly ice cream cone was right there, almost within touching distance. It was quiet and peaceful, not another soul around.

My next moonlit trip was to High Rock Lookout. This is on the Sawtooth Ridge to the southwest of Mt. Rainier. One can see the lookout and the ridge from near Cowtz Creek or from Sunshine Point Campground in Mt. Rainier National Park.

It is about a three mile roundtrip hike along a good trail from Towhead Gap. The elevation gain is probably close to 1,000 feet. The only drawback is the 17 mile drive on a logging road from a turnoff point just the other side of Ashford.

On this occasion we had a happening. A number of us packed in food, wine and guitars. It took us an hour to hike from Towhead Gap to the lookout. Once we got there we were careful to find comfortable and safe spots for everybody because the dropoff from the cliff stretches almost 2,000 feet to Cora Lake below.

Once more the sunset was gorgeous with Rainier, Adams, St. Helens and Goatrocks bathed in the warm glow of

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and of themselves are neither bad nor good, nor over the medical issue, the therapeutic effectiveness of ice, but from the patient's perception that something was clearly out of line. We emphasize strict business measures to control costs and improve our productivity. The issue we have yet to deal with is how it is perceived by our patients. Have such measures increased the public perception of medical practice as simply another way of earning a living?

Many of the trends in the above discussion have been around for quite some time. Recently, however, they have begun accelerating, and the possible consequences have generated considerable discussion and concern. In such a context it is useful to speculate on what might happen if these trends were carried to the extreme. Simply as a hypothesis it is worth looking at the questions, "What would happen if medicine were entirely reduced to a business commodity? What if medical practices were simply a service industry?" Several consequences immediately suggest themselves.

We now have smaller and smaller subspecialties which provide better and better services, but with progressively less patient interaction.

One probable outcome would be significant loss of professional stature. Physicians have been granted their social role, despite a conflict between the healing arts and medicine as a livelihood because both physicians and the public have striven to retain humanitarian concerns. The importance of this has been written about in numerous articles. It is important for the patient to ascribe humanitarian concerns to his physician, and physicians in turn have long recognized that there is a distinct placebo effect in such stature which contributes to a patient's recovery. To the extent that medicine can be completely reduced to a commodity, to that extent patients will lose their ability to consider a physician as a humanitarian. The physician will lose his claim of being unique; he will be only one among many providers. One has a glimpse of this in the rise of chiropractic reimbursement, naturopaths, nutritionists and the like. If medicine is just a pie, why shouldn't everyone get a slice? If a lay person cannot judge the scientific validity underpinning a given claim, and if all one is after is a quick fix, why should M.D.s have the whole pie? Again, the issue is not the effectiveness of medicine as a science, but rather the perception of the physicians by the patient.

A second likely outcome if medicine were to completely evolve into a business venture, entirely concerned with marketing medical product lines, is increasing susceptibility to certain laws of the market place. One of these is economy of scale. It is likely that the trend towards aggregation would accelerate. It is not clear at the present time whether this would sort itself out into IPAs, PPOs, or the like. It is clear that it would lead to the eventual demise of the individual practitioner and increasing loss of autonomy.

A third likely outcome is physician advertising. It has been pointed out that marketing is becoming an increasing, if not the major, concern of many hospitals, leading to marketing methods which invariably reach the point of advertising. Because of antitrust considerations medical societies are no longer capable of barring professional advertising. If the experience among dentists and lawyers can serve as an example, if the expected rise in numbers of physicians accelerate professional competition, there will be increasing pressures for doctors to advertise. At present the only obstacle is an ingrained sense of professional ethics among the medical community. If we speculate, however, that medicine in the future would be only a business concern

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Auxiliary News

ROUND UP

Auctions, style shows, daffodils and Valley meetings. These are a few of my favorite things. Thanks for letting us know by your attendance and participation that these are a few of your favorite things also.

PCMS Auxiliary's Combined New and Past Board Meeting, May 4— PCMS Auxiliary Year End Meeting, May 18

Friday, May 4 at 10:30 A.M. the Combined New and Past Board Meeting will be held at the Tacoma Golf and Country Club. All out going board members are requested to bring three copies of their final reports. A no-host lunch will be served after the meeting.

The PCMS Auxiliary will meet at the home of Sharon Lukens on Friday, May 18, 11:30 A.M. for the concluding program of the 1983-84 year. Dr. Tom Irish will speak on "Open Thoughts and Straight Talk About Cosmetic Surgery." Don't miss this meeting!

March 16 Style Show Big Success

The March 16 style show, presented by Littler's was a great success. Dorothy Grenley and her committee planned a very special event for auxiliary members and their guests.

Thank You

Many thanks to Kit Larson and Debbie McAlexander for organizing the April 7 auction and gourmet dinner. Our thanks also to all those cheerful and generous contributors; without you there would be no auction.

Once again Barrie Mott graciously hosted the traditional spring Puyallup Valley meeting at her lovely home. Alberta Burrows and her committee are the ladies to thank for the delightful brunch.

—Janet Fry

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and health care only a specific commodity or product line, then the rules of marketing will prevail and the pressures to openly advertise will be irresistible.

One of the most potentially profound outcomes may be the increasing susceptibility of health care to computerization. At the present time we would loudly assert that no one would want a computer as their doctor. For now that is probably true. Yet given the impact that computers are likely to have on future social structures it is worthwhile to scrutinize the issue a little more closely.

Medical care has always had three basic components. One is the cognitive, the mastery of a body of information; the second is affective, the behavorial interactions between a caring physician and a needful patient; and the third is manual, that is the skills needed to carry out physical diagnosis or surgical intervention. In the foreseeable future it will be relatively difficult to relegate the affective component or the manual component to a machine. It will, however, be increasingly easy to have a computer take over the cognitive component. Within the cognitive domain physicians function simply as information brokers. They gather data, correlate them with known data bases and determine conclusions on probability. There is little doubt that computers will be able to do this every bit as well within the near future. Thus if we assume that the affective component becomes progressively de-emphasized and that delivery of medicine is reduced to a commodity sold by providers and bought by consumers, there is considerable evidence that computers can deliver such a commodity faster, cheaper and more accurately.

There are two implications to this outcome, one immediate and technical, and the other social. The immediate implications of computer interactions in medicine have been apparent for some time. It is now possible to take a complete history via patient interaction with a monitor by branched programming. EKGs can be reduced to digital signals, analyzed, and a list of diagnoses in order of probability printed. The list is expanding rapidly.

Implicit in economy of scale is the possibility of eventual hospital dominance of the market place. For many years there was an ongoing concern about "socialized medicine," the dominance of medicine by the government. What actually appears more likely in the foreseeable future is dominance of medicine by groups large enough to have departments totally concerned with economic development, fiscal controls and marketing expertise. Individual physicians don't have the time or the expertise to accept such a role. To the extent that business concerns become paramount in the delivery of medical services, to that extent hospitals are likely to dominate the profession.

Technical predictions about computer capability are common place. We have all

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Managing the Business Side of Your Practice, continued from page 10

We are living in an area which is seeing a dynamic explosion of advertising in the health care field. Within the next two months you will become aware of advertising which you will consider marketing, and some which you may consider "hard-sell."

Evaluate each of these according to the service which is being stressed, the people who are being solicited, the effectiveness of the campaign. Learn from them and incorporate into your own plans those things which are acceptable to you.

For your promotional plan to be successful, you must make a significant and ongoing commitment of time, energy, and dollars. You must determine an acceptable level of investment that you are willing to make in promoting your practice . . . then stick to the plan. It can be a critical element in your ability to cope with the competitive 1980s.

Information for this article was taken from, *"Challange of the 80s"* Michigan State Medical Society; *"Marketing Strategies for Private Practice"* American Medical Association.

—*Dolores Lunstrum*, Owner
Management Resources

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the setting sun. On this occasion the moon was already up in the sky so the transition from one kind of light to another presented us with a new experience.

In the far western horizon we could see the lights of a city. We were not sure whether it was Eatonville or Puyallup, and then it did not matter. We enjoyed listening to the delighted comments of my friends as they filled their eyes with the sights and their souls with the wonderment of the beauty around.

There are many other places almost made to order for moonlit hiking. West Tiger Mountain in Issaquah Alps, Grass Mountain and Suntop Lookout out of Greenwater, Mt. Fremont Lookout out of Sunrise in Mt. Rainier National Park, Kelly Butte Lookout and others.

And so, if you have moon in your blood or in your astrological chart, would you like to try, too?

—*Marcel Malden*, MD

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been exposed to news about what the computer will do to our home finances over the next 10 years. Social implications of computerization, however, are only now emerging. The business world is facing enormous changes due to the information revolution similar to changes faced by the blue collar class during the industrial revolution. It now appears that the main impact of this revolution will be on middle management levels, specifically those members of corporate staffs responsible for gathering information from field operations, correlating it, organizing it into reports and passing it on to senior executives for decisions. These jobs are disappearing and the prediction is that they are gone for good, independent of recovery from a recession. At present the implications of this for medicine seem too far in the future to speculate upon. The increasingly rapid development of computer power, however, may bring the future to us faster than we would care to believe. Large numbers of solid middle class corporate employees had very little idea five years ago that they could be replaced. A combination of economic pressure from the recession and an enormous improvement in computer power proved them wrong. Physicians deal in a fundamental way with information. Computers will continue to improve and economic pressures are likely to increase. If we become only a service industry, we will not be entirely immune from the social upheavals that the information revolution may bring.

A final possible outcome that would have to be faced by the medical profession, should delivery of health care ever be completely reduced to a business commodity, is an ethical one. We will have to formulate an ethic of limits. We have in the past believed that everyone in some way has a right to health care and that everything possible should be done to preserve life and restore health, regardless of cost. We are slowly coming to the realization, in a technical sense, that such ideals may not be always possible. Technically we have the ability to extend or prolong life into situations which are clearly not justifiable ethically.

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CLASSIFIED

Washington—Directorship and Staff positions available with Ed in Centralia. Flexible 24 hour shifts; 1½ hour drive from Seattle and Portland. Attractive community, excellent area for outdoor recreation. Approx. minimum guarantee/FFS $53,000 to $67,000 with paid malpractice. Please call Medicus Medical Group at (415) 441-8232 or send C.V. to 1373 Post St., San Francisco, CA 94109.

Good Tax Shelter—24 two-bedroom apartments for sale or limited partnership. Bonney Lake. Low vacancy; management available. By owner: 964-6672 or 582-9474.

Elegant Fircrest Contemporary—That special custom home you have dreamed of with soaring open-beamed ceilings, window-walled kitchen with oak cabinets, spacious dining room & skylighted master bedroom bath/spa & dressing room off 19' x 16' master bedroom. Gracious entertainment areas, heat pumps, tile roof, 3 car garage & view. $194,500. Call Nita Tindall 564-5252 or 564-0832, Hawkins-Poe, Inc.

For Sale—Active Family Practice in Tacoma, price negotiable. Includes leasehold improvements, fixtures, equipment, supplies. P.O. Box 110577, Tacoma, Wa 98411.

For Sale—Office equipment to set up new office, including exam room and office furniture. Call: 584-1911.

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For Lease—Quad Professional Building, 1st Ave. S. and S.W. 356th, Federal Way, WA. New 3-story building for Medical/Dental professionals, ready for your tenant improvements. Ownership available through lease terms. Call today for more information. Mike Miller, 244-5706 or 284-7343 (evenings). Portal West Realty.

Gig Harbor Practice Opportunity—Fully equipped medical office at Harbor Park Professional Center. Available for immediate occupancy. 1,080 square feet of space with top quality equipment. Ideal for primary care or share with other sub-specialist. Call (206) 851-5578 for details.

For sale—Two, 8-month-old exam tables. 272-3520, Dr. Holm.

Part-Time or Full-Time Physician needed to share office space in pleasant rural setting in Eastern Pierce County. Please contact Christine Jacobs, Lake Tapps Family Medicine, 862-8001.

Medical Building for Sale in the Sea-Tac Medical Center, Federal Way. 2,079 sq. ft., includes 3 exam rooms, lab and physicians' office with private entry. Room to expand in daylight, lower level. $195,000. Contact Mike Miller, 244-5706 or 284-7343 (evenings). Portal West Realty.

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Washington: Expanding Physician-Owned Emergency Group has opening for full-time career oriented emergency physicians in South Central Washington. Excellent benefits, including malpractice, disability, health insurance, profit sharing, etc. Flexible work schedules. Excellent working and living conditions. Contact Donald Kougl, MD (307) 234-4795, or send C.V. to EMP, P.C., P.O. Box 3398, Casper, WY 82602-3398.

DR. RANDY VALENTINE, D.V.M.:

OTHER BANKS BARKED. NORTH PACIFIC BIT.

After nearly seven years of operating out of rented buildings, The Animal Emergency Clinic decided it was time to build a building designed to their very specific needs.

They looked at three banks.

Then the clinic group went to a specialist: North Pacific Bank, The Business Bank. North Pacific financed the 2,500 sq. ft. clinic at 56th and Durango.

"It's the first clinic in the state designed and built for emergency purposes," said Dr. Randy Valentine, current chairman. "It's a trauma center, open when other veterinary hospitals are closed—weekdays from 6:00 p.m. to 8:00 a.m., noon Saturdays to 8:00 a.m. Mondays and all holidays."

"The clinic provides crisis doctoring and full time emergency medicine much the same as the Emergency section of a regular hospital. There's a veterinarian on the premises with trained assistants throughout the night. Animals are never left alone."

"There are 20 partners involved in the ownership of the building. To get 20 veterinarians to agree on anything is a miracle. But we agreed unanimously to go with North Pacific."

Why?

"They gave us the best proposal, seemed most interested in our business, were close to our new location and we can see the value in dealing with a specialist, of course."

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If your business needs an emergency specialist, call 472-3333.

NORTH PACIFIC BANK
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Medical Care: A Service Industry?
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As a result, within the domain of technical progress medicine is now groping towards ethical ways of limiting health care delivery. If the present caps on reimbursement were hypothetically carried to their extreme form we would also have to create an ethic of limits based on economic considerations. If health care can be packaged in the form of diagnostic-related groups and if society as a whole determines that total expenditures for health care shall be limited to a certain percentage of gross national product, then in some way there will be economic constraints on who will receive care. The profession currently has no ethic by which to deal with this problem. An example was the discussion in the Seattle press of payment for services at the Fred Hutchinson Center for bone marrow transplantation. The center clearly has a need to recoup its costs, and the patients have a life-threatening need for medical services. What if they can't pay? We as a profession and society as a whole are hard pressed at the present time to refuse care solely on an economic basis. In England, however, due to economic constraints society has in fact said "No" to certain levels of care to certain patient populations. It is reasonable to assume that if reimbursement limitations become firmly established for specific DRGs that we will, likewise, have to develop an ethic of limits, of saying no to specific types of patient care, simply because there are no means of paying for them.

Will the above conclusions occur? There is not yet enough hard data to say that they will, but there is considerable concern that they might. Up to a point society accepts and tolerates the practice of medicine, as we know it, as a business and a livelihood. The pendulum, however, appears to be swinging somewhat off center. Government, the courts and the health care delivery system itself are pushing medicine relentlessly toward a service industry. We, as a profession, need to begin examining measures which can help to push the pendulum back towards the center.

— *William A. Gruber, MD*

Medical Society of Pierce County

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MAY 8 GENERAL MEMBERSHIP MEETING NOTICE

"COGNITIVE AND PROCEDURAL FEES" PHYSICIAN REIMBURSEMENT

What is the value of physician's services? . . . Who decides? . . .
What changes are coming? . . . By whom? . . .
What changes can be made? . . . By whom? . . .
What do doctors get paid for? . . . How much?
Which services? . . . Which physicians?
The Tuesday, May 8 General Membership Meeting will address these and other questions, open to all members of the Medical Society of Pierce County.

Presented by: Eugene Ogrod, II, M.D., J.D., Consultant in Internal Medicine, Medical/Legal and Health Policy, Sacramento, California

DATE: Tuesday, May 8, 1984

PLACE: Fircrest Golf Club, 6520 Regents Blvd., Fircrest. (Take Fircrest exit off Highway 16. Proceed on Regents Blvd. to the Club which will be on your left.)

TIME: 6:15 pm—no host cocktails
7:15 pm—dinner
8:00 pm—program

COST: $14.50

Register today. Space will be limited. Mail this form, with a check for the appropriate amount, to the Medical Society in the business reply envelope provided. Or, call the office, 572-3667, to confirm your attendance. Make check payable to Medical Society of Pierce County (MSPC).

REGISTRATION

Yes, I have set aside the evening of May 8 to hear "Cognitive and Procedural Fees"

☐ Reserve ____ dinner(s) for me at $14.50 each (price includes tax and gratuity).
Enclosed is my check for $__________.

Dr.______________________________ Telephone________________

RETURN TO MEDICAL SOCIETY OF PIERCE COUNTY NO LATER THAN FRIDAY, MAY 4

An added complication... in the treatment of bacterial bronchitis*

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes*, group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy — Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy — Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor®-cefaclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[illegible]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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May, 1984

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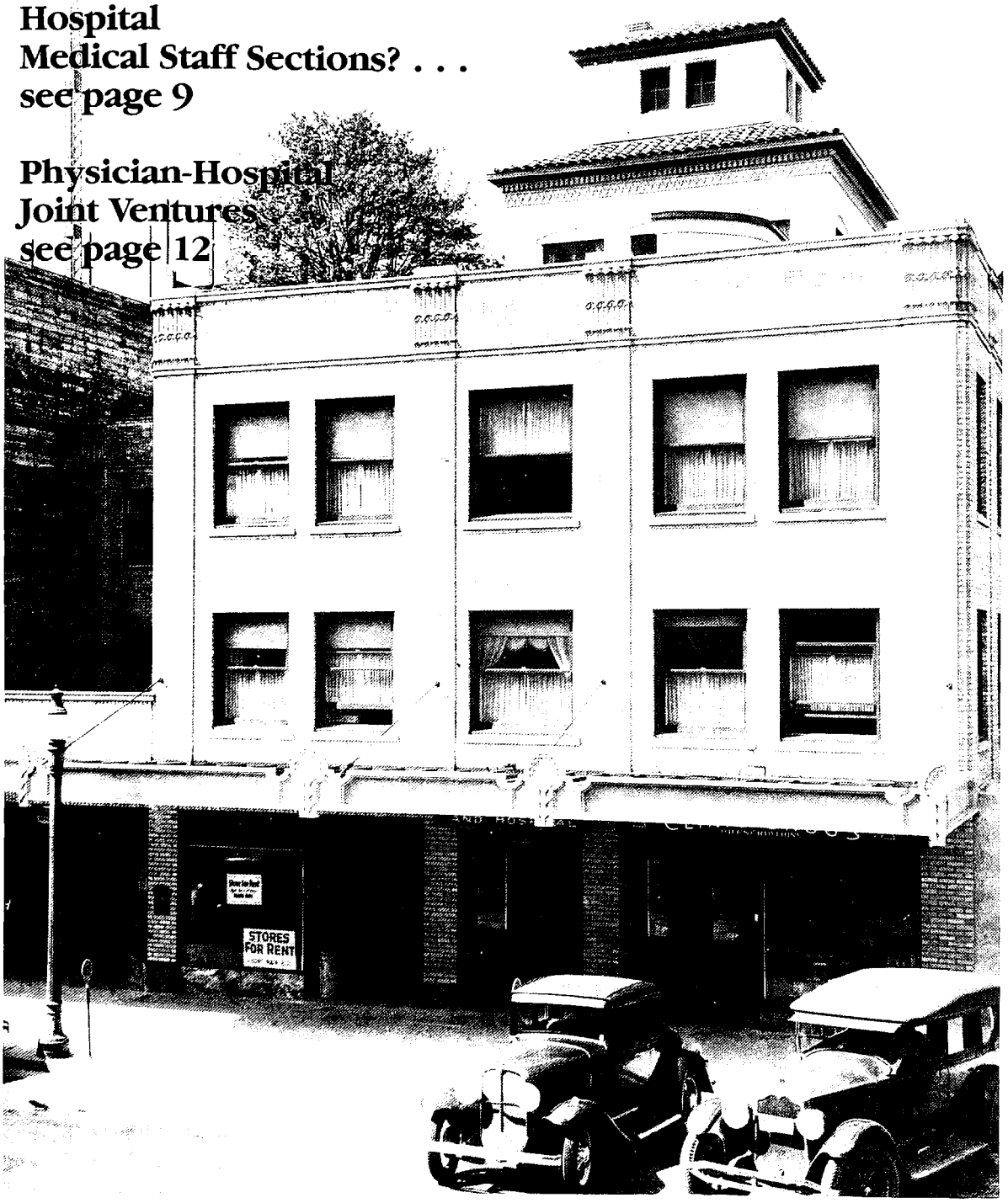

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The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Cover photo: courtesy of Tacoma Public Library. Bridge Clinic and hospital, 744 Market St., Tacoma, WA, 1931. Opening May 2, 1931, the 70x120 ft., five story building was hailed as one of the finest of its types among medical institutions on the Pacific Coast.

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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President's Page

THE CONSUMER SPEAKS: NOT ABOUT FEES

My last several columns have been politically oriented in the main. In this issue, I would like to change the tone and speak of the amenities of medicine that are all too often forgotten.

Most of us have a genuine, sincere and thoughtful concern for the patients we treat, whether it be for life-threatening illnesses or run-of-the-mill colds, flus, fractures and the like. My focus—and that of the patient—generally is centered on the specific reason for the medical visit.

I think it is valuable to step back from this focus once in a while and ask ourselves, what other concerns might patients have that are not directly related to their medical visits? In other words, what do our patients think about us in a general way? What are their hang-ups, their gripes about us, if you will?

Without the help from the Roper, Gallup or even the TNT pollsters, but with significant help from my older brother, Bob, we conducted a survey. Here are the results.

Although not the sole province of physicians and health care providers, there seems to be the impression that saying "thank you" and "I'm sorry" is fading from the American business scene. This, in itself, is surprising, because we expected medical costs to be the number one complaint among survey respondents. (Admittedly, our survey included only a limited number of persons. But this response is telling in any event.)

Technical advances in the art of medicine were cited as being increasingly proficient. Concurrent with this perception of medical advances, however, is a perception that the old, one-to-one relationship between physician and patient has suffered. In years past the doctor saw the patient, diagnosed the illness, prescribed treatment and then waited to be paid. If you were lucky, you did get paid and said, "Thank you, Mr. Patient."

With the advent of clinics, multiple physician practices, burgeoning office staffs, etc., this practice is gone. Now, at the conclusion of a medical visit, most of us, in the eyes of survey respondents, simply say, "See the girls at the desk with this slip," as we hand them the charge slip. I do this. I think most of us do. There goes our specific, one-on-one association.

Couple this with the multitude of medical insurance forms that normally must be completed by the patient, and one can understand the perception of the medical consumer that he or she is "just a number". Hospitals, in particular, are criticized for this. But private practitioners are not immune from the criticism.

In addition, we found that many of our patients have a total lack of understanding about who actually is paying their bill when we get a check from Pierce County Medical, Medicare, or some other insurance company. Even though in the last few years there has been increasing public awareness of how medical insurance works, a significant number of medical consumers seem to think that Pierce County Medical Bureau is some kind of a philanthropic institution which automatically pays their medical bills. All too often, there is not the recognition that employers contribute vast dollars to a "savings account" in order to pay for employee illnesses. The intermediary is Pierce County Medical Bureau or some other association.

I do not suggest that we spend great portions of our valuable time thanking every individual or association who pays us. I do suggest, however, that from time to time we could say, "And, by the way, thank you for paying your last medical bill so promptly." This would accomplish several things. First of all, it would make our patients aware that these medical insurance companies are, indeed, valuable to them. Second, I believe it would result in more satisfied patients because they would realize we actually took the time out to look at their individual charts or files.

"Sorry, it's been one of those days." We all have them. Complications at the hospital, surgery, rounds, emergency calls and yes, even personal problems, detain us and back up our appointment schedules. Patients, usually scheduled for appointments by those "girls at the front desk," arrive at the proper hour. They check in, and then they wait and wait—sometimes for an hour or two.

We should assume (and I suppose most of us do) that a patient's time is as valuable to him or her as our time is to us. Whether patient or physician, we all have just 24 hours a day. Now, you know why you are late. Does the patient? You come in the back door and start at the top of your appointment list, while the other patients continue to wait.

Sometimes one of the office staff will inform patients that the doctor is late, and their appointment will probably be delayed. (Their first clue comes when they arrive and can't even find a chair in which to sit in the waiting room!) But the doctor's delays don't give patients back their waiting time.

Again, I am not suggesting that we spend all our time saying "I'm sorry" for these unavoidable delays. But when they are particularly long, it might not hurt to explain to the patient, "I'm late because of such and such." I always am pleased when someone does this for me; I'm sure our patients would feel the same.

Now, perhaps I'm the only one of us that doesn't do these things. And if I am, I have this little story to tell: Sam had 12

continued on page 8

Local News Briefs

IN MEMORY OF DR. J. ROBERT BROOKE

J. Robert Brooke died on March 3, 1984. A native of Seattle, he graduated from the University of Washington and McGill University Medical School. He returned to the Pacific Northwest to intern at the old Pierce County Hospital. After two years at that institution, he left to work for the American Smelting Refinery Corporation. (Tacoma Smelter). World War II came and after several years active duty in the U.S. Army Medical Corp., he resumed a private medical practice in Tacoma, beginning in 1946.

Besides his professional organization, Bob had many community interests. Both he and his wife, Ruth, were very active in the Pierce County and Washington Chapter of the American Cancer Society. He was president of the County group and a life member of the latter. He was involved for years in organizations promoting the Annual Daffodil Festival.

Bob had a major interest in several fraternal organizations, including Masonic Orders and also the Afifi Shrine Temple. Perhaps his greatest love was for the Tacoma Elks Lodge, where he was a past Exalted Ruler. Later he was active at the state and national level. Many of these Committees were concerned with lodge charities, largely medical related.

For many years, Bob had been an avid supporter of Tacoma Amateur Athletics. The local Class A Basketball Tournaments had him as a physician and sponsor as did the local Golden Gloves. He was a member at Fircrest Golf Club. Later when he and Ruth moved into the Lakes Area, he played at Oakbrook Golf Club. He was a real golf enthusiast, rain or shine. In recent years he did not hit the ball as far as in the past, but this in no way diminished his interest or enthusiasm.

Bob spent almost forty years as a family practitioner in this community. He had a large faithful practice for whom he worked long and hard. Occasionally I had the opportunity to read his office records, he wrote beautiful histories; his follow-up notes were most meticulous, a sign of a careful physician.

A few years ago I was present at a surprise 70th birthday party given by his patients and friends. It was pleasing to see the honor and the esteem given to one whom had given them so much of himself all the past years.

Robert will be missed always by his family, his professional colleagues, friends and by all of his many devoted patients.

—Robert H. Gibson, MD

WSMA ANNUAL HOUSE OF DELEGATES MEETING GIVES MEMBERSHIP OPPORTUNITY TO SHAPE WSMA POLICY

The annual meeting of the WSMA House of Delegates, the physicians' policy making body at the state level, will be held September 14-17 in Seattle. Physicians will have an opportunity to shape WSMA policy at this meeting on virtually any medically related issue by submitting resolutions for deliberation to the House of Delegates.

Members interested in submitting resolutions are asked to contact the appropriate MSPC chairman, or if there is no committee relating to their area of concern, a MSPC officer/trustee. Deadline for submission of resolutions is late July.

JoAnn Johnson to Run for 28th District House Seat

JoAnn Johnson (Ralph), long time activist and participant in Pierce County Medical Society Auxiliary activities has entered the political arena. JoAnn announced her candidacy as a Republican for the 28th District House seat.

Interested in politics since her youth and active in party matters, JoAnn is no stranger to Auxiliary elective office-holding. She has served as President of Pierce County Medical Society Auxiliary and the Washington State Medical Association, serving on the original Liability Steering Committee. For six years she was the Washington State Medical Auxiliary 6th Legislative District Representative to WAMPAC.

JoAnn and Ralph have lived in the Lakewood area since arriving in Pierce County in 1961. They are the parents of two boys and one girl.

AUXILIARY NEWS

Generosity is alive, well and living in Tacoma, Washington! Thanks to all of you who so generously supported the PCMSA Auction: the talented contributors, the active participants in the auction itself, the behind-the-scene workers, and, of course, many thanks to co-chairwomen, Kit Larson and Debbie McAlexander.

Auxiliary news is sparse this month, as our year is rapidly coming to an end. Next month's *Bulletin* will announce the recipient of the Student Recognition Award and the Philanthropic Awards. The results of the election for the 1984-1985 slate of officers for the PCMSA will also be announced.

—Janet Fry

Local News Briefs,
continued from page 5

JOINT MEMBERSHIP MEETING DRAWS OVER 115 MSPC MEMBERS

Over 115 MSPC members and Madigan Army Medical Center physicians met at the Fircrest Golf Club, April 3 for the traditional Joint Membership Meeting.

Col. Wergeland and president Duffy presided over what was a very enjoyable evening for all attending. MAMC physicians Plymate, Fletcher, Redmond and Bohman gave presentations on such interesting and diverse topics as Aging and Testicular Function; Hepatitis B Vaccine—Current Concepts and Strategies; Spinal Computed Tomography; (CT) Scanning in the Evaluation of Metastatic Disease; and Adult Typhlitis: Neutropenic Cecitis, Diagnosis and Treatment.

Photo by Linda Carras

President James "Pat" Duffy presiding over April 3, Joint Membership Meeting with the staff of Madigan Army Medical Center.

Photo by Linda Carras

Puyallup physicians were well represented at the April 3, Joint Membership Meeting with (from left to right) Drs. Arnold W. Johansson, James K. Symonds and William H. Morrison admiring the program.

Photo by Linda Carras

Left to Right: Dr. Richard Welch, Chief of Preventative Medicine, and Dr. Duong Nguyen, Resident Physician in Public Health at Madigan Army Medical Center talking with R.M. "Bud" Nicola, MD, Director, Tacoma-Pierce County Health Department at the April 3, Joint Membership Meeting.

MARK YOUR CALENDAR

Meeting dates for upcoming
General Membership Meetings

September 11, Tuesday, 6:15 P.M. Sheraton Hotel
November 13, Tuesday, 6:15 P.M. Sheraton Hotel
December 11, Tuesday, 6:15 P.M. Joint meeting with the PCMS Auxiliary, Sheraton Hotel

PIERCE COUNTY STUDY POPULATION FOR NATIONAL STUDY ON HEPATITIS

Occurrence of Hepatitis A,B, and Non-A/Non-B in the United States CDC Sentinel County Hepatitis Study I

From "The American Journal of Medicine," Volume 76, January 1984

To gain more insight into the epidemiology of all types of hepatitis in the United States, the CDC began the Sentinel County Hepatitis Study in mid-1979. This study has collected serologic and epidemiologic information on hepatitis cases reported from five selected counties.

The study criteria used to select these counties resulted (by design) in the inclusion of counties with high reporting rates, moderate to high rates of hepatitis, and high interest in hepatitis. Not by design, the counties that joined the study overrepresented the Southwest and underrepresented the Northeast. This is the initial report from this ongoing study.

Perhaps the most important finding from this study is the high proportion of acute hepatitis that is neither hepatitis A nor hepatitis B. It is evident that non-A/non-B hepatitis is a significiant problem in the country. Overall, one fourth of all hepatitis cases reported in these counties were non-A/non-B hepatitis, and in two counties (Pierce, Washington and Pinellas, Florida), one third were in this category.

CDC intends to further elucidate the clinical and epidemiologic aspects of these diseases with additional studies in these sentinel counties.

TABLE III Incidence of Hepatitis A,B, and Non-A/Non-B by County

	Rate per 100,000 Population/Year		
County	A	B	Non-A/Non-B
Pinellas, Florida	4.7	13.6	6.1
Jefferson, Alabama	3.8	14.4	7.5
Orange, California	24.0	18.9	9.9
San Diego, California	32.6	18.6	10.7
Pierce, Washington	8.9	10.8	11.5

TABLE IV Distribution of Hepatitis A,B, and Non-A/Non-B Cases by Age

	Hepatitis Type		
Age (years)	A (n = 328)	B (n = 251)	Non-A/Non-B (n = 211)
0-14	43* (13)†	3 (1)	9 (4)
15-29	178 (55)	177 (69)	121 (58)
30-44	79 (24)	45 (17)	39 (19)
45 +	24 (7)	33 (13)	41 (20)
Unknown	4	3	1

*Number of cases.
†Percent of cases by type.

TABLE V Risk Factors for Hepatitis as Acknowledged by Patients (Percent)

	Patient Diagnosis		
Risk Factor	A	B	Non-A/Non-B
Day-care center contact	11	4	8
Foreign travel	14	9	5
Previous contact with a hepatitis patient	26	22	12
Homosexual preference	15	12	4
Illicit drug use	10	26	16
Transfusion	0	5	12
Previous hospitalization	6	16	21
Surgery	5	10	14
Other percutaneous exposure	6	15	14
Medical/dental worker	6	12	9
Any risk factor	60	70	52
No risk factor	40	30	48

TABLE I Reported Cases and Percent Serotesting by County

County	Months in Study	Cases Reported	Cases Tested	Percent
Pinellas, Florida	19	286	123	43
Jefferson, Alabama	13	203	122	60
Orange, California	20	1,726	397	23
San Diego, California	13	1,327	146	11
Pierce, Washington	15	207	159	76
Total		3,749	947	25

TABLE II Proportion of Hepatitis A,B, and Non-A/Non-B by County

	Type of Hepatitis Cases (percent of all)		
County	A	B	Non-A/Non-B
Pinellas, Florida	20 (18)	54 (49)	36 (33)
Jefferson, Alabama	15 (14)	64 (59)	30 (27)
Orange, California	199 (56)	74 (21)	81 (23)
San Diego, California	56 (55)	28 (27)	18 (18)
Pierce, Washington	38 (30)	41 (33)	46 (37)
Total	328 (41)	261 (33)	211 (26)

Note: Pierce County has been awarded exclusively a contract by CDC for active surveillance of primary care sources to enumerate viral hepatitis cases diagnosed over a six-month period.

This surveillance will consist of personally contacting physicians' offices, emergency rooms, emergency medical clinics, hospitals, nursing homes and state institutions. To verify collected data, laboratories, employee and student health services, and other secondary reporting sources will be surveyed. Study results will be sent to all participants.

UP IN SMOKE

The Tacoma/Pierce County Board of Health met April 5 to consider Resolution #63". This resolution would ask city and county governments to adopt ordinances that would prohibit tobacco smoking in certain enclosed public places and in the work place (office environment).

Dr. Alan Tice, member, MSPC Board of Trustees and chairman for the Ad Hoc Committee on Smoking, represented the Society. Presenting the Society's viewpoint to the Board of Health, Dr. Tice outlined the numerous health effects of tobacco smoking and its impact on the population.

Dr. Tice said the implications tobacco has on the nonsmoker cannot be over estimated, whether they are heart/lung disease patients, asthmatic children or healthy, normal individuals who cannot tolerate the many chemical components of tobacco smoke.

Members of the Board of Health were very responsive to Dr. Tice's testimony. Dr. Tice answered many of their questions concerning health defects and the legal problems encountered in adopting such legislation. Following Dr. Tice's testimony, the Board of Health unanimously passed the resolution.

County/City members of the Board of Health will take the resolution back to their respective councils to draft ordinances for public hearing. Members of both councils have asked for Medical Society input to assist in drafting the legislation.■

The Consumer Speaks:
Not About Fees, continued from page 4

children and Jane, his wife, was pregnant again. Sam met with his family physicians and the doctor said, "Sam, you simply have got to stop this yearly production of children. You have so many now that they are ill-fed, ill-clothed, and not getting the attention they need." Sam replied, "I *have* quit, doc, and I swear to you that if this happens again, I'm going to kill myself."

Five months later, Jane was pregnant again. The doctor, once again, met with Sam and began to chide him, "Sam . . ." Quickly, Sam cut in: "I know, doctor. I was going to kill myself. I had a heavy rope attached to the highest four-by-four in my hayloft. The noose was around my neck and I was about ready to jump when a loud, booming voice came out of nowhere: 'Sam, Sam, you might be hanging an innocent man!' "

I hope in this column that I have not "hung" any innocent physician or surgeon. As we all become so involved in the technological aspects of medicine, I fear that our bedside manner, such an important aspect of medicine in the past, has been lost to blood gasses, blood chemistries, scans, angiograms and arteriograms. Let us not forget the humane aspect of our profession.

Recently, I was a patient in a hospital—thank God, only for a few short days. It gave me tremendous insight into how we physicians accept our day-to-day routine with little consciousness of our individual patient's feelings and needs. If the responses we received in this random survey are in any way accurate, I suggest we ought to expand that consciousness.

—*JPD*

WHAT HOSPITAL MEDICAL STAFF SECTIONS HOPE TO ACCOMPLISH

By Marie Kuffner, MD

The following article is reprinted from the Los Angeles County Medical Association Magazine, November, 1983.

"I foresee inclusion of a physician payment into each hospital DRG. Thus, there would be one lump sum payment to be shared by the physician and the hospital. That payment would not necessarily have to be made to the hospital. In fact, if a physician-sponsored organization were willing to accept the entire payment and contract with hospitals for institutional services, all the better. After all, it is physicians—not hospitals—who manage patient care."

That quote by David Durenberger (R-Minn.) was spoken at an AMA conference on PROs and prospective payment recently held in Washington DC.

Statements such as this are made every day in the halls of government.

Although the practice of medicine, especially hospital-based medicine, has been at a crossroad of significant change, it currently is at the threshold of the most sweeping legislative action of recent times. Witness a whole new alphabet soup—DRG, PRO, MESH, PPO—to name just a few. Add to these the recent applications in the hospital of such concepts as contracting, credentialing, competition, the super corporation and satellite clinics.

As Paul Starr put it in his book *Social Transformation of American Medicine,* "Doctors and hospitals may be on a 'collision course' as doctors invade institutional services and hospitals invade ambulatory care [and] the growing supply of doctors is almost certain to increase tensions between hospitals and their medical staffs."

Is it any wonder then that the idea of forming a special section within the present structure of organized medicine—namely, the Hospital Medical Staff Section—has met with such overwhelming enthusiasm at every level? No less so, when the LACMA-HMSS held its first official meeting on October 10, attended by representatives from more than 100 hospitals within the county.

As stated in its rules of procedure, the purpose of the newly formed section is to "provide a direct means to address the relationship between members of the Los Angeles County Medical Association and hospital medical staffs." In addition, the section shall act as a vehicle for formulation of resolutions to be forwarded to LACMA Council, CMA and AMA for legislation and action as well as discussion of local issues which will be resolved internally.

The formation of the LACMA-HMSS follows right on the heels of the inaugural meeting of the AMA-HMSS held last June in Chicago—a meeting which attracted more than 700 participants representing 48 states. Simultaneously a CMA-HMSS is being organized and will have its initial meeting on Thursday, December 1, at the Bonaventure Hotel just prior to the AMA Interim Meeting. What is happening in Los Angeles and in California is being repeated across the nation as the urgent need to strengthen medical staffs starts to be felt throughout the federation.

The history and background of a separate hospital medical staff section dates back to the turn of the decade when the AMA conducted a study of the current relationships between physicians, individually and collectively, and hospitals. Included within the investigation were the identification of issues and problems unique to hospital medical staffs and the exploration of needs and services necessary to strengthen them. What prompted the study in the first place was the changing medical care environment and the trends in hospital structure and management of the 1980s.

During the previous decade the practice of medicine underwent dramatic changes. Most significant was probably the beginning of a trend that will continue into the 1990s—namely, the rapid growth in the number of physicians. In 1971, across the United States, there was one physician for every 658 people. In its May/June *Socio-Economic Report,* CMA noted that the physician supply had climbed 3.7% in California in 1981, the latest date for which figures are available. In San Francisco, there was one physician for every 160 people and in Los Angeles one for every 397 people.

Thus in 1981, the state of California had one active physician for every 440 residents, while the national average was one physician per 553 persons.

While the physician numbers continue to rise, so does the growth of for-profit hospitals and multi-hospital systems as well as an increasing dependence on the hospital for the delivery of modern medical care brought about by advancing technology. These trends are evident as they have led to increasing numbers of physicians entering full-time, part-time or negotiated contractual relationships with hospitals and other health care facilities. By the end of 1981, approximately 191,000 physicians had some contractual relationship with hospitals or other health care facilities.

The trends in hospital structure and management indicate that by the end of this decade 50% to 60% of all hospitals may be part of some multi-unit system. In addition, hospitals attempting to increase

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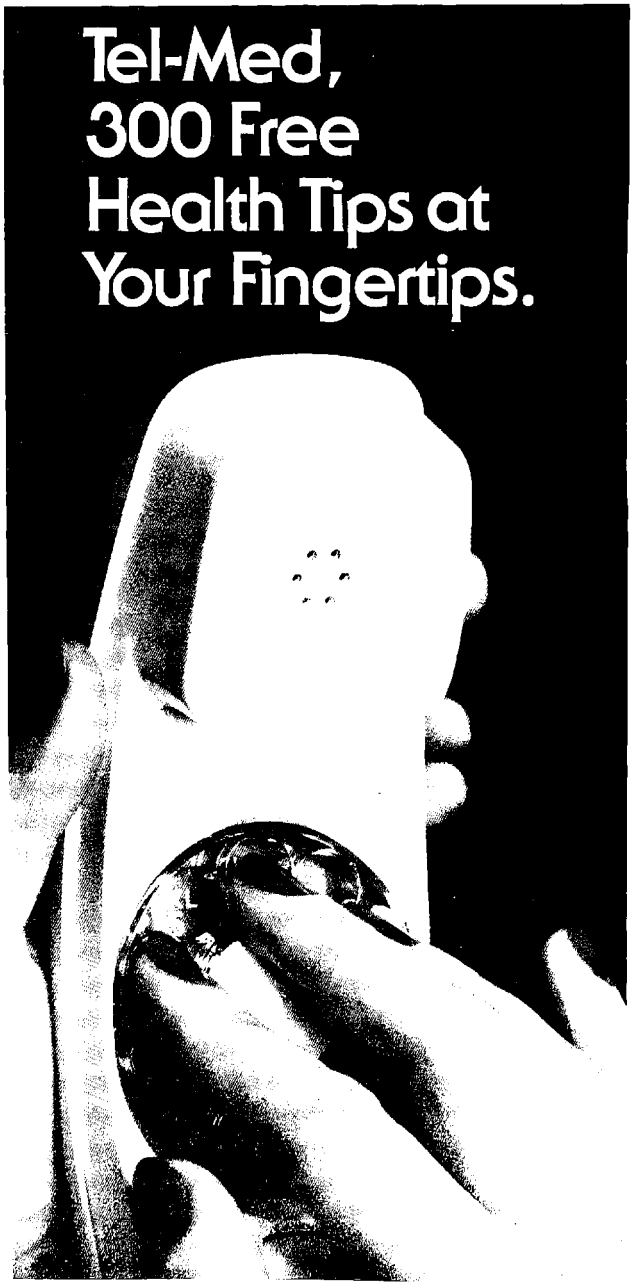

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MEDICINE AS A PRIVATE ENTERPRISE

By George Tangen, MD

Dr. Tangen, a practicing otolaryngologist in Minneapolis, Minnesota, is president of the Hennepin County Medical Society. The Society conducted a Joint-Venture Seminar in April. Representing Pierce County physicians and hospitals at the April Seminar were Doug Robson, MD, Good Samaritan Hospital; Ralph Johnson, MD, and Phillip Koon, Associate Administrator, Lakewood General Hospital; Drs. Bishoff, Houtz and Spaulding and Assistant Administrator, Charles Hoffman, Multicare Hospital; Dr. Billingsley and John Maher, Assistant Administrator, St. Joseph Hospital; Doug Jackman, Executive Director, Medical Society of Pierce County.

Dr. Tangen addressed the February AMA Leadership Conference to describe his Society's approach in developing hospital-physician relationships. The following is his presentation at the AMA Leadership Conference.

A schematic diagram of the Hennepin County physician-hospital joint venture concept (MeSH Central) is presented on the opposite page.

The Minneapolis health care market is one of the most competitive in the entire nation. Approximately 35% of our population is now enrolled in HMOs. Six PPOs have been or are being organized; 20% of our Medicare population is now enrolled in HMOs. Minneapolis was once considered a unique oddity in the national scene. It is now apparent that maybe we are not unique, but perhaps only further along the path towards an organized health care system.

What are some of the current trends in the health care market place. The DRG reimbursement system, the physicians surplus. We are experiencing the effects of the physician surplus in the Minneapolis area. In addition, we have a surplus of hospital beds; two of our smaller hospitals have closed their medical-surgical units within the past year. There is competition between our hospitals. There is competition between our physicians; there is competition between our hospitals and physicians.

Urgent care centers have been developed or are in the planning stage. It has been estimated that up to thirty of these institutions might be considered for the Twin City marketplace. Some of these by hospital corporations.

Independent surgical centers are in existence or are being planned to compete with the hospitals' one day surgical centers. Groups of our physicians have united to staff after hours clinics to compete with their hospital emergency rooms. Many of our hospitals have, or are undergoing a corporate restructuring to enable them to compete in the nontraditional hospital areas that deliver health care services.

There is intense advertising by our hospitals and HMOs. It has been estimated that in the year 1984 over $10 million will be spent by hospitals at HMOs in the Twin City area.

In reviewing these trends in health care, it became apparent that in many areas physician and hospital interests overlap. In the summer of 1983, the Board of Directors of the Hennepin County Medical Society authorized the formation of a committee to devise a joint venture model whereby hospitals and their physicians could work together as equal partners to confront the forces that threaten the well-being of both groups.

These joint ventures might include a DRG management system. The cooperation of physicians is vital to insure that hospital costs are controlled without a reduction in patient care quality. The present DRG system provides for few incentives for physicians to cooperate. A joint venture could create those physician incentives.

Health plan ventures such as PPOs or HMOs could be developed. Facilities and services ventures, such as surgery centers, urgent care centers or possibly office facilities might fall under the joint venture framework. A variety of other ventures might be considered, including possible financing opportunities.

The committee raised a number of questions that were to be answered. What possible benefits could there be to the hospitals and physicians. A joint venture could provide a balance between physician and hospital interests. It could minimize the amount of change while making enough adaptation to compete successfully in the health care marketplace. It could help reduce the potential for conflicts between hospitals and medical staffs.

To achieve these benefits will require that the hospital staff organize. The hospital corporation is a coordinated business unit with a defined mission, with internal governments and decision making mechanisms and the proven capacity to act as a consolidated business unit.

When one looks at the existing medical staff, it is composed of independent and generally small groups of independent practitioners. It really is a loose professional association of small businesses which generally compete against each other. It is most often a fragmented, disjointed organization that is unable to deal with sensitive issues and certainly not in a business like manner. Therefore, we need to structure a separate physician organization which could serve as an economic unit, leaving the medical staff intact.

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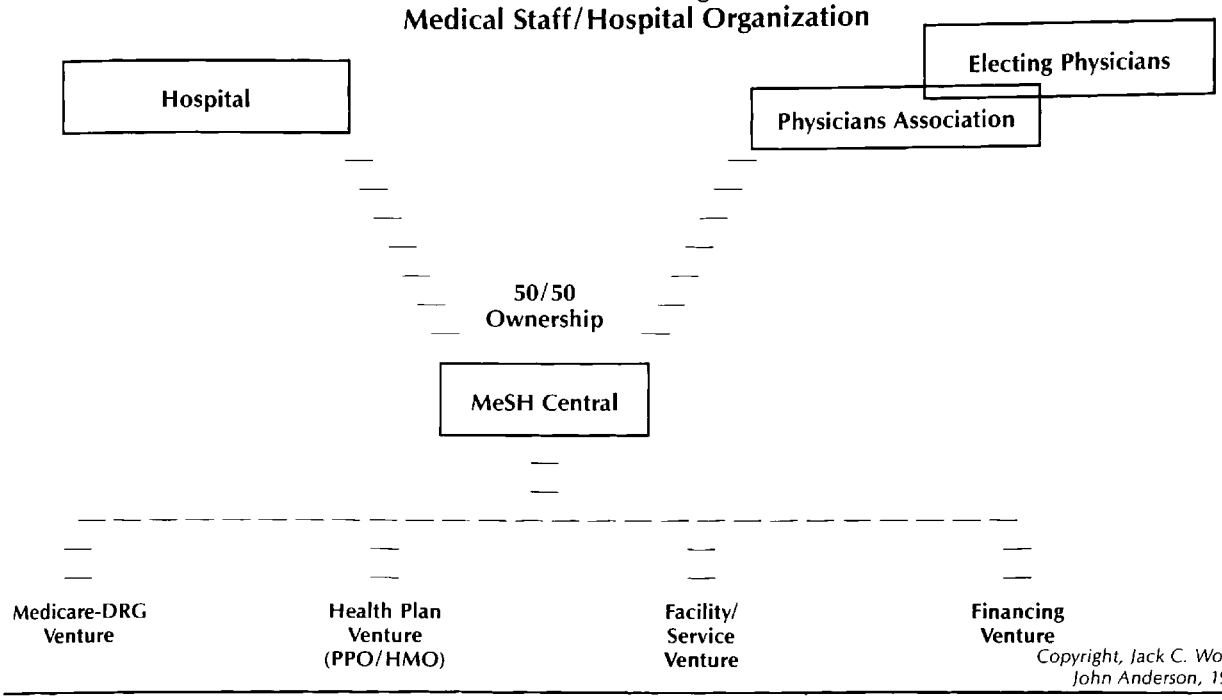
Figure 1

Schematic Diagram
Medical Staff/Hospital Organization



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A separate physician organization will allow the medical staff physicians to formalize their relations with the hospitals and speak to the hospitals with one voice. It may legally define medical staff relationships and provide physicians equal voice in hospital joint venture decisions.

What are the barriers to joint venture physician hospitals? Joint ventures may force the hospitals to share their planning and policy with physicians before the ideas become policy. It may be an advantage to physicians, but maybe felt by the hospitals to be a disadvantage.

Joint ventures may restrict individual physicians entrepreneurial natures. Hospital-physician joint ventures may also fragment the community in the specific competing hospital alignments. It may also not be possible for physicians to organize and arrive at a consensus, so to speak, with one voice.

At this point, our committee was faced with the following options. Should we have no involvement? Should we have educational seminars for our membership? Should we proceed to develop a model or should we assist medical staffs in negotiating joint venture opportunities. It was the recommendation of the committee to our Board of Directors that we proceed with the development of a model. This was approved by the Board of Directors.

The question then arose—could the Hennepin County Medical Society in conjunction with area hospitals and their staff physicians work jointly together to develop a model. We subsequently invited the chief executive officers from 14 area hospitals and their respective chiefs of staff to a meeting where we reviewed the major issues and invited their participation in the project.

Twelve of the hospitals and their medical staffs agreed to participate in the project. It appears that at least at a planning level the hospitals, the medical staffs and the Medical Society could cooperate.

In late August of 1983, a joint venture steering committee was formed with representatives from both administration and medical staff of each participating hospital. In addition, the officers of the

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revenues will seek to expand services specifically in the areas of ambulatory care and outpatient day surgery.

Large hospital management corporations and hospitals will be in increasingly open competition for their share of the marketplace. All these forces will push the influence of medical staffs and the issues of patient care far behind the incentives for profit making and economic power.

Beyond the number of physicians who have financial arrangements with hospitals *and* who are classified as hospital-based, greater than half of all office-based physicians spend more than 20% of their practice hours in hospitals. Surgical specialties which comprise 30% of this office-based population are virtually captives in this system, as surgeons require an affiliation with a hospital to operate. It follows then that since physicians spend a significant portion of their practice time in hospitals, that hospitals have the opportunity to exert considerable influence on the way medicine is practiced. On the other hand, the hospitals provide the logical arena where joint and common problems between medical staffs and institutions can be discussed and resolved.

Having considered the history leading to the evolution of a hospital medical staff section, let us now examine the issues facing this group and identify some short- and long-term goals.

In a recent survey of physician attitudes, more than half the respondents indicated that they had detected a change in hospital and medical staff working relationships over the last five years, and most felt the change was negative.

Among the most important issues identified by the respondents were:

- Lack of medical staff voice in hospital and planning.
- Lack of medical staff voice in hospital and governing board decisions.
- Closed medical staff arrangements and/or exclusive contracts.
- Interpreting and complying with JCAH standards.
- Role of non-physician health care providers in the hospital.
- Interspecialty jurisdiction in delineation of privileges.

During the inaugural meeting of the LACMA-HMSS, an issue survey was disseminated and the results show that the following were most important:

- Contracting as it relates to hospital staffs, including closed and open panels, PPOs, IPAs, etc.
- Peer review, discipline of physicians and related matters. Should PROs review cases in communities distant from the reviewing doctors? Who reveiws and who sets the standards?
- Paramedical personnel and their roles in supervision and peer review.
- Professional liability reform.
- Credentials and medical or surgical privileges.
- Hospital bylaws, including rights and responsibilities of doctors on hospital staffs.

The formation of a hospital medical staff section came about to focus on these and other related problems and to represent the hospital medical staff members because as the hospital continues to evolve as a significant provider of health care services, the degree of physician involvement with hospitals will continue to increase as well. To serve the growing needs of the medical staff in the current environment, the HMSS must provide a system to solve problems and to avoid polarization of medical staffs and other groups. It must also develop and maintain information on issues of common concern and distribute data on successful approaches. At the same time, it must act as a vehicle to affect change in policy and legislation that will improve quality of medical care without compromise on issues of cost or standards of medical practice. This is no small task indeed!

In a recent survey of physician attitudes, more than half the respondents indicated that they had detected a change in hospital and medical staff working relationships over the last five years, and most felt the change was negative

Broadly stated, the issues and resolutions passed include:

continued on page 15

What Hospital Medical Staffs Hope to Accomplish, continued from previous page

- Equal payment for psychiatric coverage.
- Separate legal counsel for hospital medical staffs.
- Stipends for chiefs for medical staffs.
- Confidentiality of internal medical staff activity.
- Physican involvement in hospital advertising in media.
- Indemnity insurance.
- Only fully licensed physicians to evaluate patients' overall medical needs and determine related medical staff policy.
- Physicians' right to a hearing for any adverse action.
- Compensation to physicians and private facilities for MIA emergency admissions.
- Medical staff bylaws, emphasizing autonomy of medical staffs.
- Separate fee justified for reoperation regardless of time relationship to first surgery.
- Conflict of interest re: governing-body-appointed physicians on medical executive committee.
- Data collection of insurance company payments.
- Physician responsibility for hospital chart and face sheet data.
- Changed basis for burden of proof at disciplinary hearings.
- Verification of secret ballot.

The medical care environment is changing in ways that will increase the need for representation of medical staff in the formulation, development and implementation of new policies in the area of physician-hospital relationships. LACMA hospital medical staff section is a positive force which will afford us an avenue to negotiation and understanding. With the advent of greater government control, hospitals and hospital staffs will be facing many of these same problems. It is imperative that we participate in a "win-win" environment for each side where common concerns can be resolved. Failing this, both the hospitals and their medical staffs will be reacting to the pressures of an ever-encroaching system of government regulation. What is required then is not an adversarial approach, but rather an attitude of cooperation and understanding between us. Strengthened, united and informed hospital medical staffs is a concept whose time has come.■

Medicine as a Private Enterprise, continued from page 13

Hennepin County Medical Society served on the steering committee.

The committee agreed to retain Mr. Jack Wood of the law firm WL&E to provide overall legal direction. We retained Dr. Paul Elwood and Mr. John Anderson from Inner-Study to develop and do the conceptual design work for the project. We also retained a local law firm to work with Mr. Wood with regards to the legal issues specific to the State of Minnesota.

A budget was established and the Medical Society and participating hospitals each contributed their allocated contributions towards the costs. The overall cost of the project was $150,000.

In September of 1983, the steering committee met with all the consultants to develop a work plan and a time table for the project. A four month schedule was adopted for completion of the project. The work plan calls for the development of a unified but flexible model for structuring economic joint ventures between a hospital and members of its medical staff.

Beyond the basic program, the consultants were charged with detailed legal scrutiny of the numerous issues raised by the concept and the production of model documents that could be used to effectuate a joint venture system.

The written description of the model plan and the model legal documents have been completed, and we are now in the process of dissemination of this information to the participants.

The centerpiece of the system is the creation of a new business entity created by the basic partners, the hospitals and their physicians. This new entity has been named Mesh-Central. Its purposes are to provide a forum for establishing policy and strategic plans, to identify, evaluate and develop specific health care venture opportunities of mutual interest and benefit to the hospitals and physicians and to develop and provide to the several possible joint ventures those management tools necessary to succeed.

A number of major issues have been addressed by the consultants. Physician participation—physician participation would be open to all members of the active medical staff. A new physicians' association would be created, but individual physicians would maintain their freedom of choice on whether or not to participate.

The physicians association would be a partner with the hospital in the ownership and governance of Mesh-Central. The existing medical staff organization would not be changed. The medical staff functions would continue to focus on the internal professional management of the hospital. The new physicians' professional association would focus on specific joint venture activities and partnerships with the hospitals.

The process of selection of joint venture board members is outlined in the report. The physicians' own association would be a 50% stockholder in the Mesh-Central. It would be the stockholder, the investor, the advocate for physicians' interests, the enforcer of physicians' commitments and responsibilities, and the protector of physicians' rights. It would be at risk for its investment in Mesh-Central with all the associated financial rights and responsibility.

The joint venture project has given us a form of legal entity best suited to the physicians' association in Minnesota. It has defined the objectives and functions of the physicians association and how the association would relate with other organizations.

It provides a model for governing the physicians' association and the nature of individual physician relationships to the association. The major legal issues and constraints have been addressed.

There are no per se violations of antitrust law in the model. The joint venture

continued on page 19

SCOLIOSIS: MANAGEMENT AND TREATMENT

By Robert W. Florence, MD, FACS

After making a presentation on scoliosis to school nurses last month, Dr. Robert Florence was asked to write a short summary outlining the current state of detection and management of scoliosis for physicians of our society. The following is Dr. Florence's summary.

Scoliosis screening examinations, now nation wide, have been done in the Tacoma and Pierce County schools since 1968, making this area one of the earliest to start such a program.

The State of Washington requires mandatory screening from grades five through eight in all public schools. Most parochial schools have an equivalent but voluntary program.

It has been gratifying to see the results of screening over the years. School nurses have become very proficient in identifying even minimal curves and getting the children in for evaluation by their family physicians or pediatricians with subsequent follow-up and referral for treatment when indicated.

Approximately 75% of the scoliosis cases are hereditary idiopathic variety. School screening reveals the incidence to be about equally divided between the sexes. About 80% of those requiring treatment, however, are females. Our schedule of treatment follows:

Curves under 10° and 20° —Follow at 4 month intervals. I usually start them on an exercise program. Exercises will not correct a curve or even prevent it from progressing, but I believe exercises can help a child become more posture conscious, and strengthen muscles. Even though we are doing something, however, the patient and parents should be advised honestly of our expectations.

Curves over 20°—Active treatment. Until recently this meant bracing which has evolved from the bulky, visible Milwaukee brace to the present light weight plastic brace without a visible superstructure that can be completely undetected if appropriate clothing is worn over it.

An alternative to bracing now available is the electrical stimulation treatment. We are using a stimulator called the Scolitron, manufactured by Neuromedics. Battery operated, this instrument stimulates the muscles on the convex side of the curve by using transcutaneous electrodes.

The Scolitron is worn every night for a minimum of eight hours. This current is automatically applied for 6 seconds followed by 6 seconds of relaxation. Electrical stimulation treatment is appealing to children because no bracing or other treatment is required during the daytime, so they can be normally active, physically and socially.

The FDA approved the use of the single channel stimulator in December 1985. The dual channel stimulator, used when it is necessary to treat 2 curves, is still under investigatory regulation, and requires following a rigid protocol when using it.

Curves over 40° —Surgical treatment. This involves spinal fusion and using one of the corrective and internal fixation devices, such as the Harrington Instruments.

While early detection and non-operative treatment is the preferred management, there are a few patients who get around the screening network or refuse treatment when the curve is mild and treatable by conservative means. There are still a few curves that will progress in spite of our best efforts, and surgery is our best answer for these patients. Because of the special problems congenital, paralytic and other types of Scoliosis present, it is advisable to seek early consultation with an orthopedic surgeon for most of them.■

MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

John B. Coombs, MD, *Family Medicine.* Born in Washington, D.C. 1/23/45; Cornell University Medical College, New York City, N.Y., 1972; internship, Children's Orthopedic Hospital, University of Washington, Seattle, WA, 6/72-7/73; residency, Pediatrics, University of Washington, 7/73-7/74 and Chief Resident in Pediatrics, University of Washington, 6/78-7/79. Washington State License, 1974. Dr. Coombs is currently Director, Tacoma Family Medicine, 721 Fawcett, #24, Tacoma.

Mary E. Stanton-Anderson, MD, *Obstetrics/Gynecology.* Born in Pasadena, CA, 4/3/53; UCLA, Center for the Health Sciences, Los Angeles, CA, 1979; internship, Harbor UCLA Medical Center, Torrance, CA, 6/79-6/80; residency, 7/80-6/83. Washington State License, pending. Dr. Stanton-Anderson is currently practicing at Group Health Cooperative of Puget Sound, Tacoma.

Rebecca A. Sullivan, MD, *Family Practice.* Born in DeQuoin, IL, 9/21/42; Creighton Medical School, Omaha, NE, 1975; internship, Family Practice, USAF Medical Center Scott, Scott AFB, IL; residency, Family Practice, USAF Medical Center Scott, Scott AFB, IL 7/76-6/78. Washington State License, 1979.

Haven Silver, MD, *Family Medicine.* Born in Los Angeles, CA, 3/10/46; Chicago Medical School, N. Chicago, IL, 1972; internship, Family Practice, Harborview Medical Center, Seattle, WA, 6/72-6/73; residency, Family Practice, Cheyenne, WY, 2/81-2/83. Washington State License, 1973. Dr. Silver is currently practicing at Group Health Cooperative of Puget Sound, Tacoma.

Medicine as a Private Enterprise, continued from page 16

model makes every attempt to minimize exposure to anti-trust violations under the rule of reason. The joint venture concept appears to have sufficient competitive intentions which should reduce the prospect of enforcement authorities wishing to challenge the concept itself.

The financial issues have been addressed in the report, including how the joint venture would be capitalized and the estimated costs of creating a joint venture.

We have created a unified but flexible prototype model for structuring economic joint ventures between hospitals and members of their medical staffs. This prototype model is being distributed to the 12 participating hospitals and it is now going to be up to them to decide whether they will adopt all or part of this model to incorporate into their health care system.

The physicians' group presented in the schematic diagram on page 3 has two boxes. This is an important part of the model in that all members of the medical staff may not be members of the new physicians'association. It is the opinion of the Hennepin County Medical Society that in a highly competitive environment like we have in the Twin City area those hospitals and their physicians who are able to work cooperatively together will be the winners. Those who don't, may ultimately lose. We feel the joint venture model will give them the opportunity to survive.

—*George Tangen*, MD

PHYSICIANS AND SPOUSES ATTENDING MARCH 13 CAUCUSES TO INFORM MSPC OFFICE

The Legislative Committee requests that all physicians and/or their spouses who attended the recent, March 13, caucuses inform the MSPC office.

Committee chairman Dr. James Druger would also appreciate knowing if any of you are going on to the county convention.

Our apologies to Dr. Dennis Wight. Dr. Wight's name was incorrectly spelled in the advertisement for the Tacoma Fertility Clinic in the April Bulletin.

CLASSIFIED

Northeast Tacoma Professional Center—Great Location above Brown's Point. New professional office space. Two blocks from Jr. High. Energy efficient. Full basement for mechanical and storage. Interiors to suit. Super competitive leasing terms. This great community needs a medical office. Dennis/Jean (206) 272-2713.

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Professional Office Space—Plaza 128, on South Hill, fastest growing community in Pierce County. Finest office space available. Designed for medical professionals and conveniently located, with plenty offstreet parking. Sizes from 852 sq. ft. and larger, with competitive rates, flexible layouts on attractively landscaped grounds. Call Steve Lawson, MICHAEL J. RUBEL & COMPANY, (206) 531-8528 or 584-8382.

For Sale—Active Family Practice in Tacoma, price negotiable. Includes leasehold improvements, fixtures, equipment, supplies. P.O. Box 110577, Tacoma, Wa 98411.

For Sale—Office equipment to set up new office, including exam room and office furniture. Call: 584-1911.

Planning an Open House? Professional organizers, invitations, food and beverage, hostessing, clean-up. FREE estimates. SUNSHINE VENTURES, new location: Sheraton Tacoma Hotel, 572-9330. Kari Stackpole, Suzanne Jordan.

Plaza 19 Professional Center—Up to 2,500 sq. ft. of beautiful new office space remaining, near Allenmore. Generous leasehold incentives make it worth moving to this unique office location. Call 752-6622.

For Lease—Quad Professional Building, 1st Ave. S. and S.W. 330th, Federal Way, WA. New 3-story building for Medical/Dental professionals, ready for your tenant improvements. Ownership available through lease terms. Call today for more information. Mike Miller, 244-5706 or 284-7343 (evenings). Portal West Realty.

Gig Harbor Practice Opportunity—Fully equipped medical office at Harbor Park Professional Center. Available for immediate occupancy. 1,080 square feet of space with top quality equipment. Ideal for primary-care or share with other sub-specialist. Call (206) 851-5578 for details.

Medical Building for Sale in the Sea-Tac Medical Center, Federal Way. 2,079 sq. ft., includes 3 exam rooms, lab and physicians' office with private entry. Room to expand in daylight, lower level. $195,000. Contact Mike Miller, 244-5706 or 284-7343 (evenings). Portal West Realty.

View Home—Gig Harbor: Now $120,000 by owner. I've slashed $16,000 off the price on this 2,800 sq. ft., 3 bedroom home with many amenities. Must sell by summer before mortgage rates climb to 15%. Call George: 1-851-5248.

For Sale: Medical Practice—Suburban Tacoma, 1,600 sq. ft. Two large examining rooms, minor surgery, X-ray and lab. Phone 537-8656, P.O. Box 44488, Tacoma.

For Sale or Lease—Tacoma Medical Center Building #5; six rooms, nurse's station PLUS. 1,013 sq. ft. basement, furnishings and equipment optional. Mrs. J. R. Brooke, 1206 S. 11th, Building #5, or 584-6030.

GP Retiring—Walk in and take over. Reasonable terms. Beautiful Mt. Vernon, 3 blocks from hospital. 428-2626, day or night.

Washington: Expanding Physician-Owned Emergency Group has opening for full-time career oriented emergency physicians in South Central Washington. Excellent benefits, including malpractice, disability, health insurance, profit sharing, etc. Flexible work schedules. Excellent working and living conditions. Contact Donald Kougl, MD (307) 234-4795, or send C.V. to EMP, P.C., P.O. Box 3398, Casper, WY 82602-3398.

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"Things are pretty well back to normal," says Lyon.

"But realtors who think they are in the same real estate business today are dead wrong. Victor L. Lyon Realtors is in the information business. We've got more information about people, houses and investment real estate than anyone else. We try to put them together. We now have five offices and 90 sales people."

His is also a family business. Son Jeff handles the commercial investment and property management divisions. Son Neil handles the residential division and financial management. Daughter Dyann will sell about $3 million in residential real estate this year.

"But I also want to tell you that the grass we're sitting on for this picture is part of a plan designed by my third son Marty, a landscape architect."

"North Pacific has always been there when I've needed them. They handle my company business and my personal business. They financed the first house that I built for my family 30 years ago. Jack Schweitzer has been at my house at 6 or 7 at night probably a dozen times since then to handle one thing or another."

"My kids also bank with North Pacific. That says something, too. But it doesn't mean the Old Man will cover their checks."

If you're looking for a home to live in, call Victor L. Lyon Realtors. 475-1622.

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LETTERS TO THE EDITOR

Dear Editor,

Insight is important in order to separate fact from fancy in the world of marketing.

We have observed the insidious development of medical marketing schemes, and will probably be exposed to many more in the future. I personally believe these can be deceptive to the unwary patient (today referred to as "consumer").

The Family-Care Urgent/Emergency Center has used confusing terminology in describing its services. It clearly is not an emergency center and general public confusion already exists as to the distinction between urgent and emergency medical problems.

This facility is not solely self-financed (free-standing), but is subsidized by Lakewood General Hospital in the format of building and equipment leasing arrangements. (Per Tacoma-Pierce County Economic Development Board.)

Since it is illegal in the State of Washington for a hospital to practice Medicine, a separate sub-corporation was formed by Lakewood Hospital, bypassing this legal requirement.

The AMA has requested that if such centers, and there are thousands, advertise themselves as Emergency or Urgent Care Centers, then these centers should assume the responsibility such labels imply (i.e., open 24 hours with full specialty back up; full access to intensive care; and surgical care units).

More appropriately and more accurately, the best alternative is to identify these services as "Episodic" and would better therefore be termed "Episodic Care Centers."

It is hoped the public will be better served by knowledge and accuracy in advertising.

Edward A. Drum, MD
Gig Harbor, WA

IS THERE A DOCTOR ON THE SLOPES?

By Linda Carras

This is a true story as told me by a friend.

It really wasn't her fault. How could she know? After all she was a novice. She couldn't afford the latest ski wear, so she resourcefully used what was available, even her old, one-piece thermal underwear. How could she know this might lead to a broken leg?

It happened this way.

Time and place: Winter of '82, Stevens Pass. She and a friend were riding the chairlift to the top of the slope.

It was a long ride and she got chilled en route. Unfortunately there was no relief station at the destination and her bladder had reached bursting point. She couldn't wait! She searched for an inconspicuous, tree sheltered area.

The only clump of trees was strewn above the slope. So she uncomfortably trudged up to the new found haven and proceeded to undress.

Everything had to come off; the one piece thermal underwear had no drop seat. She, of course, left her skiis on. She was in a hurry, and she silently prayed that her sphincter muscle would continue to cooperate. It did.

Now came time to re-dress. She was already slipping around on her skiis.

She tugged firmly at the legs of her thermal underwear with so much force, however, that she propelled herself forward and unwillingly traversed out from behind the trees and down the hill. PANIC SET IN!

Imagine, a novice skiier at the top of a slope quickly proceeding down it, undressed, except for thermal underwear flying in the wind.

She wasn't scared. More like TERRIFIED! HORRIFIED! MORTIFIED!

This wasn't a time for tears, but fast thinking. So she thought fast, as fast as her skiis plummeting down the fall line, but there were no answers.

She couldn't turn, she couldn't stop and falling down au natural in the snow (at high speed) wasn't considered.

She tucked her body in a curl to hide her head and protect her upper body. Little did she know this is a racing position.

Finally, the bottom of the hill appeared and she stopped successfully, crashing into the lift line.

She broke her leg. But this was not the end.

The ski patrol whisked her away to set her leg and reunite her with her clothes.

As she was receiving treatment, another skiier was brought in who had broken his leg.

He was an accomplished skiier she had previously seen maneuvering down the hills with grace and ease.

She inquired how this fate befell him. He told her she would never believe him. He saw a naked woman careening down the hill and on watching her, he lost his concentration and did the tango with a tree.

She quietly said, "I'm very sorry you got hurt." He then asked her, "And what happened to you?"

State Seeking Review Positions in Olympia

The Washington Office of Disability Insurance is seeking physicians in the psychiatric field to review medical evidence and disability claims under the Social Security and Supplemental Security Income programs. *Physicians are asked to commit a minimum of 20 hours per week at our office in Olympia.*

Payment is according to the Washington Consultative Physician's schedule. Orientation to the disability program and office space will be provided.

Interested physicians are asked to contact *Eleanor E. Giffin, M.D.*, Chief Medical Consultant, or *John E. Peters*, Professional Relations Manager, Office of Disability Insurance. They can be contacted on a toll-free line **1-800-562-6074** or at the following address:

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Olympia, Washington 98504

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The Bulletin

MEDICAL SOCIETY OF PIERCE COUNTY

June/July, 1984

Dr. Kenneth Graham Honored

See page 8

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The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

1984-85 MEDICAL SOCIETY DIRECTORY FOR PHYSICIANS AND SURGEONS SCHEDULED FOR PUBLICATION IN SEPTEMBER

The 1984-85 Medical Society Directory for Physicians and Surgeons is scheduled for completion in September, is in the production stages. If you have not filled out an order form or turned in the information necessary to update your current listing in the Directory, please do so by July 15, 1984. **No order will be guaranteed after the July 15 deadline.** *Physicians who do not return a form will be listed as they were in the 1983 Directory.*

You may use the form below to order additional copies of the directory. *Payment for the Directory must accompany your order.* No order will be accepted without payment. *If you previously ordered a Directory and did not enclose payment, order again, using the form below and enclose payment.*

Each Medical Society member will receive 1 complimentary copy. Cost for additional Directories for members is $7.50 per Directory. For non-members, $8.50.

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The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Cover photo: Dr. Kenneth Graham, Tacoma Family Physician. Dr. Graham received the Washington State Family Physician of the Year Award. Story on page 8.

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted

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President's Page

ON PROFESSIONAL COURTESY

It has been my observation, and the subject of many doctor's lounge conversations, that there is a widening gap between physicians, nurses, pharmacists, physical therapists and other personnel within our hospitals and offices.

I have some reason to blame this on our rapidly advancing technology. On the other hand, I also feel this phenomenon is the result of misunderstanding and the failure to respect the various roles of medical personnel. It is, I suppose, easy for me to say, "Let's go back to the good old times when the physician was 'king of the mountain' and everyone else was underneath him (there were few 'hers' at the time)." Nurses rapidly stood up as the physician approached the chart desk; they were at the physician's disposal for anything he wanted, on an ASAP basis. There was no doubting or questioning of any orders that the physician wrote on the order sheet.

We all must recognize that these times have disappeared. We now have a more integrated system in which our non-physician medical personnel are on more equal level. We, as physicians, must realize that the nurses' responsibilities have increased dramatically in both action and outcome. Their educational backgrounds have advanced as fast as medical technology. Their basic knowledge of the inpatient often approaches that of the physician. While it may be true that our patients have suffered some loss of "TLC" from their doctors, it also is true that there has been a decrease in morbidity and mortality due to better qualified nurses.

We, as physicians, all have our pet peeves. We hate to be awakened in the middle of the night for some simple order that appears obvious to us. But the medical system no longer operates under the old premises. We physicians must have the respect, competence, courtesy and willingness to discuss a patient problem with the nurses at any time—day or night. As in many other aspects of medicine, it is a new ball game: The old one is history.

Pharmacists within and without our hospitals have assumed a broader role as well. They not only fill prescriptions; they advise patients on the side effects of medicine and of their inter-reactions with other medication. They sometimes even question doctors about their specific orders. This, in particular, sometimes gives rise to ego-eroding and even anger on the part of some of our colleagues.

But the extensive protocols developed within hospital pharmaceutical departments, as well as private pharmacies, are excellent and should be followed when at all possible. Yes, some of them fail, just as some of our treatments fail. Nevertheless, they represent a refinement in the treatment of our patients.

Similar additional responsibilities have been assumed by our physical therapists, occupational therapists, respiratory therapists and other specialized groups in our hospital system in the last few years. I do not and cannot stay in command of all medical advances. This was well-illustrated to me by a recent observation of a new respirator being used for the first time on one of my patients.

Frankly, I had a difficult time finding where to turn on the machine, let alone a mastery of the multiple dials, buttons, etc., on it. The pulmonary specialist gave me a 30-minute lesson about the machine as he intubated my patient. I found it most interesting and instructive. This situation is typical of many others, I would guess.

In review, I am asking for increased concern for and cooperation among all medical professionals. All of us must accept the specialties and subspecialties as they today exist. All of us must recognize our own limitations and do our best not to step beyond them.

Common sense in everything we do must be a paramount concern. We can no longer afford to be separated, to be egotistically aloof or pursue our own destiny without concern for the rights and the expertise of others. I ask for teamwork through our medical system—hospitals, offices, emergency medical systems, administration and other groups concerned with the health of our patients.

My own nurse, who has been with me for 23 years, recently made a remark that summarizes what I am attempting to say here: "Yes, we have had our minor differences, all connected with communication and understanding each other's viewpoints. But, over the years, we have learned to become true professional colleagues."

—JPD

Local News Briefs

SPEND AN EVENING IN CHINA SPECIAL VIEWING, TUESDAY, JULY 31

Now you can get an upclose and personal look at the many contributions and the people that make up China today, by joining other members of the Society and Auxiliary for a special evening viewing of the China Show now at the Pacific Science Center, Seattle. The Auxiliary has coordinated an evening for special viewing of the China Show for Tuesday, July 31, 1984.

Join your colleagues and friends for this very special event. The schedule will be:

6:00 P.M.	Board buses at Humana Hospital
7:00	Hors d'oeuvres—Pacific Science Center
8:00	Viewing
9:45	Board bus, return home

The cost for this excellent venture is approximately $21.50. This includes viewing the Exhibit, hors d'oeuvres, round-trip bus fare, 64 page Exhibit Guide and recorded cassette for listening during viewing of the Exhibit. If you have any questions, please call the Society office.

Bus ride and hors d'oeurves are optional. If you would like to drive up, the following prices are listed for your information:

Viewing	$7.50
Hors d'oeurves	$6.95
Guide	.75
Cassette	$2.00

SALARY SURVEYS AVAILABLE

Salary Surveys are now available from Membership Benefits. To request a copy of the 1984 Salary Survey for medical office staff positions call or write:

Membership Benefits, Inc.
Medical Society of Pierce County
705 S. 9th Street, #202
Tacoma, WA 98405
Phone 572-3709

All requests will be mailed to home addresses.

PIERCE COUNTY EMS COUNCIL REQUESTS PROPOSALS

The Pierce County Emergency Medical Services Council is requesting proposals for the establishment of a single Emergency Medical Base Station facility, and for those facilities desiring designation as a Pierce County Emergency Medical Receiving Center Hospital.

Receiving centers will be responsible for providing Emergency Medical care consistent with established standards. The Medical Base Station facility will be responsible for providing medical control via radio and phone communication to Pierce County EMS personnel.

Applications are due by September 5, 1984, 5:00 P.M. Application packets are available from the EMS council office, 420 South Fawcett, Tacoma, WA,98402. The phone number is (206) 591-5747.

GET READY FOR THE PUYALLUP FUN RUN

Sponsored by the American Lung Association of Washington, the Puyallup Fred Meyer/Coke 4-mile and 1-mile Fun Run will be held July 19, 7:00 P.M. at Clark's Creek Park No. 3, located at 14 Street S.W. and 12th Avenue S.W., Puyallup.

Entry fee is $2.00 for the 4-mile run, $1.00 for the 1-mile run. T-shirts are available for $4.00.

Late registration will be taken on race day beginning at 5:45 P.M. Day-of-race registrants, however, must pay an extra $1.00 fee.

For entry form information, call the Lung Association in Tacoma, 474-9547. Entry forms are available at all Fred Meyer stores.

Anyone interested in participating in the race who cannot run is welcome to volunteer with registration and finish line duties.

DR. JUDD RESIGNS AS CHAIRMAN OF INTER-PROFESSIONAL COMMITTEE

After seven years as chairman of the Inter-Professional Committee, Dr. Judd is resigning as chairman due to the illness of Mrs. Judd. The article in this month's *Bulletin* appearing on page 18 will be his last.

Local News Briefs, continued on page 6

GENERAL MEMBERSHIP MEETING ADDRESSES PHYSICIAN REIMBURSEMENT ISSUE

Dr. Ogrod defined the issues confronting the medical fraternity and held the interest of those attending throughout his talk. He recommended physicians help each other and work together to avoid division and bitter battles, if we are to preserve the traditional values of medicine.

The May 8 General Membership Meeting saw approximately 125 MSPC members turn out to hear Dr. Eugene Ogrod, Internist, Sacramento, California, speak on "Cognitive and Procedural Fees."

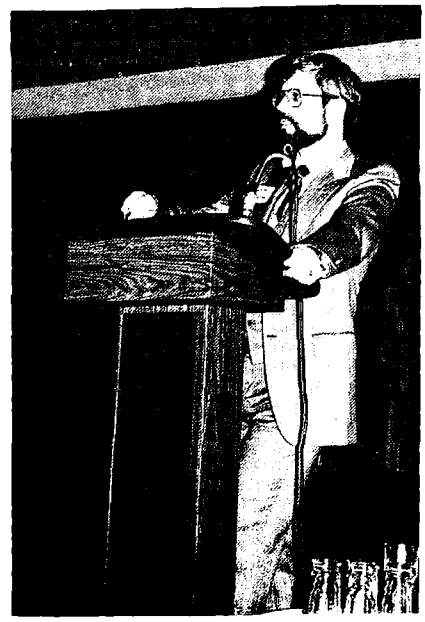

Photo by Linda Carras

Guest speaker Dr. Eugene Ogrod speaking before the MSPC membership at the May 8 General Membership Meeting encourages physicians to work together.

Photo by Linda Carras

Dr. Craig Rone (left) and Dr. Eric Luria (right) carry on a lively discussion. Dr. Rebecca Sullivan (center) talks with colleagues.

Photo by Linda Carras

Dr. Myra Vozenilek (left) and Dr. Douglas Robson (right) enjoy a relaxed moment at the May 8 General Membership Meeting.

Local News Briefs, continued on page 11

MSPC ETHICS/STANDARDS OF PRACTICE COMMITTEE RECOMMENDS HOSPITALS ESTABLISH ETHICS COMMITTEES TO FORMULATE GUIDELINES FOR TERMINATION OF LIFE SUPPORT

Over the past several months, the Ethics/Standards of Practice Committee has devoted considerable time and thought to the establishment of broad guidelines for the termination of life support. This task was assigned to the Committee by your MSPC Board of Trustees.

The Committee feels that this issue and similar ethical issues are best handled by individual hospital medical staffs and thus, have recommended that the following policy be accepted.

In the past, ethical issues in medicine, such as whether to forego treatment were resolved privately by the patient, family and physician. Most deaths occurred at home. The problems posed were less pressing than now because medical capabilities were limited. Without the capability to provide life support, many of today's issues would not exist.

Today, most deaths in the U.S. occur in institutions, and for almost any life-threatening condition there is some intervention capable of delaying death. It would appear that medical decision making regarding termination of life support will be scrutinized even more in the future as economic pressures become even more severe. It is our hope that this scrutiny will be by one's medical peers in cooperation with local hospital administrative and lay personnel.

Individuals should be able to make choices about medical care consistent with their personal morality and preferences, and these choices should be consistent with the ethics of the institution where they may be a patient. Physicians must be able to exercise medical judgement and perform effectively. There must be means to protect those who cannot make decisions themselves, i.e., the infant, the mentally compromised and the unconscious.

Thus, the Ethics Committee of the MSPC recommends that the Board of Trustees of the MSPC recommend that each of the eight Pierce County private hospital medical staffs establish an ethics committee for their institution. This committee should be multi-disciplinary in composition and should be charged with the responsibility of formulating guidelines for the termination of life support for a particular institution. It is hoped that such a committee would meet at least annually to review policy and procedures.

Reference should be made to:

1) *"Deciding to Forego Life Sustaining Treatment."* The Presidents Commission for the Study of Ethical Problems in Medicine and Bio Medical and Behavioral Research.
2) *Natural Death Act,* Revised Code of Washington, chapter 70.122.
3) *Guidelines for the Appropriate Management of Patients Who May Have Supportive Measures Withdrawn.* Vallarta, J.M., MD, Mary Bridge Children's Hospital, 1981.

It is to be expected that these guidelines and committee structure will vary somewhat: but it is hoped that by this limited recommendation on standardization, a pattern will develop that will be acceptable to the majority of the members of this society.

—Gilbert J. Roller, MD, Chairman

**MSPC Board of Trustees approved the Committee's recommendation, as stated, at their May 1, 1984, meeting.*

DR. KENNETH GRAHAM RECEIVES WASHINGTON STATE FAMILY DOCTOR OF THE YEAR AWARD

Dr. Kenneth Graham of Tacoma was awarded the most prestigious and coveted "Washington State Family Doctor of the Year" award at the annual meeting of the Washington Academy of Family Physicians held in May at Ocean Shores.

Dr. Graham needs no introduction to the Pierce County medical community. His contributions to the community are many, as witnessed by his generosity of time and talent to the many activities listed by Dr. Richard Spaulding in his letter nominating Dr. Graham for the award (below).

Dear Committee Members:

It is with great pleasure that I nominate Dr. Kenneth D. Graham for the WAFP "Family Doctor of the Year" Award. For many years now, Dr. Graham has been a leader not only in family practice at both the local and state level, but also has been involved in a multitude of other worthwhile and charitable activities. The attached profile clearly demonstrates the enormous amount of time and dedication, as well as talent, that Dr. Graham has given to organizations, societies and individuals.

After reviewing his impressive list of accomplishments, and in spite of the long list of high administrative positions held, what caught my attention was his involvement and obvious dedication to people, to individuals young and old. For over ten years, Ken was medical advisor for the Tacoma Camp Fire Girls, medical advisor for a local vocational school's medical assistant's program, and 20 years the team physician for yet another local high school. He has worked evenings for two years at the Tacoma Family Clinic, a medical clinic for the indigent, performed yearly physicals at the County Park Department for Little League football players, was the physician for the Faith Home, a residence for unwed mothers, and for 15 years provided medical back-up to the two major hospitals in Tacoma because there was a chronic shortage of Family/General Practice physicians, as well as General Internists, who were willing to participate in this rather thankless task. Singularly, these positions may not be particularly impressive, but collectively one must ask, what kind of a man would subject himself so consistently and over such an extended period of time to so many non-glamorous and seemingly unrewarding jobs? The answer, in part, is a man who sincerely enjoys dealing with people, young and old, healthy and ill, rich or poor. More important, for all these people, what image has he left behind? They are left with the image of a friendly, caring family physician who has moved out of his office and hospital setting and has come to them. They are left with a touch of the "old country doctor" image which the elderly can recall with fond memories and the young can now more clearly imagine. They are left with some of the fundamental concepts, ideally, all family physicians should possess—but, unfortunately, not all family physicians are like Ken Graham.

Ken is certainly not void of the more prestigious positions, having been elected by his peers to be President of the Pierce County Medical Society, President of the Washington Academy of Family Practice, President of the Board of Trustees of the Tacoma Family Practice Residency Program, Chief of Staff of Mary Bridge Children's Hospital, etc. etc! But what truly distinguishes Ken Graham from the many other fine family physicians is the extent of his involvement at all levels of society, in and out of the medical profession, and an almost unbelievable humility and friendly approach he has towards everyone he meets.

It is realized that there are other highly qualified candidates for this distinguished award, but I sincerely wonder if those other candidates reflect the obvious and subtle, the tangible and intangible qualities possessed so profoundly by Dr. Kenneth Graham, qualities that reflect the true meaning of family physician.

Therefore, it is an honor to nominate Dr. Graham for the Washington Academy of Family Physicians' "Family Doctor of the Year."

Respectfully submitted,
Richard K. Spaulding, MD
Pierce County Chapter,
WAFP, President

Dr. Graham was born in Aberdeen, Washington in 1930. He graduated from Weatherwax High School in 1948. In 1952 he graduated from the University of Washington, subsequently completing his medical training at George Washington School of Medicine in 1956 with an internship at San Joaquin General Hospital in Stockton, California in 1957.

Lieutenant in the United States Navy, he served as a medical officer in a destroyer division with overseas duty. He is an active member of the American Medical Association, the American Academy of Family Practice, the Washington Academy of Family Practice and the Medical Society of Pierce County.

He holds medical licenses and certification in both California and Washington. Past president of the Medical Society of Pierce County, Dr. Graham was president of the Washington Academy of Family Physicians in 1977. He chaired the committee to establish the Family Practice Residency in Tacoma for five years, spending a great deal of time in travel and meetings. He was on the Board of Trustees for the Family Practice Residency and served as the first president from 1975 to 1978.

A backpacker and mountain climber, he is one of the fortunate few to have climbed Mt. St. Helens before it blew.

As winner of the Washington State award, Dr. Graham is now eligible and a candidate for the national "Family Doctor of the Year" award. This will involve a presentation of awards at the White House.

The society wishes Dr. Ken Graham and his family the very best and thanks him for his many contributions for the betterment of the entire community.

—the editor ■

TEL-MED PLEDGE CAMPAIGN UNDERWAY

The 1984 Tel-Med pledge cards have been mailed to all physicians at their homes and offices. Physicians and physicians' families support of this valued health information service is very much appreciated. The existence of Tel-Med is dependent upon your continued support.

1984 Tel-Med Pledge Card

To Pierce County Physicians and Families

Tel-Med needs your help in order to continue its free health information service.

Today, more than ever, the public is seeking and needs factual health information. Tel-Med, with its tape library of over 300 physician approved messages, provides this service very effectively. At the same time, **valuable positive public relations** for the medical community are generated. Over 250,000 of our neighbors have called Tel-Med and each has benefited from a message that concludes with, "Brought to you by the Pierce County Medical Society Auxiliary and Physicians of Pierce County."

Now, we ask you to help Tel-Med continue. Please complete this pledge card and return it with your tax deductible contribution in the enclosed business reply envelope.

Thank you in advance for your support of this valued public service.

Shirley Kemman
Shirley Kemman, President

Norma Lloyd
Norma Lloyd, President-elect

___ $100.00
___ $ 75.00
___ $ 50.00
___ $ 25.00

MANAGING THE BUSINESS SIDE OF YOUR PRACTICE

WHERE HAVE ALL THE PEOPLE GONE?

More years ago than I care to admit to, I accepted a job in a medical office at a salary of $525.00 per month. There were no benefits, there was no retirement plan, no continuing education allowance. I was happy to have the job, the association was long lasting.

Today salaries have increased and benefits have become the number one issue for the job applicant and a considerable expense for the employer.

When interviewing a prospective employee for an office, the first questions concern sick leave, health insurance, personal days, vacation time, retirement benefits or life insurance; these questions occur even before the question of responsibilities and skills required in the performance of the job take place.

If the salary and benefits are acceptable to all concerned, if the applicant fulfills all the requirements of the job description, is well trained and competent, then we can expect that all will go well; the office will run smoothly; problems will dissolve and everyone will be happy. Right? Wrong!

What then is happening in our office environment: If the staff is better trained, better paid, if the physician and the employee are compatible, why do we see such a high rate of turn-over in the offices?

A successful office relationship is like a successful marriage. It depends on communication, cooperation, sharing and a feeling of being a part of the "team." Each person on that team needs to feel like they are doing a good job, that they are appreciated and that the physician will be supportive, and will back them up in decisions they have made.

The best trained office assistant, the straight "A" student, has only learned from the book or from the last physician he or she has worked for. This does not mean that they know exactly how you want things done . . . how you want your phone answered . . . what you consider an emergency . . . what call is important enough to call you on your pager. In order for an employee to become valued, indespensible, to be capable of making judgements when required, it takes input from the individual physician.

According to the AMA Medical Management Department, it costs between $5,000.00 and $7,000.00 to replace an employee. A high cost indeed! Why do people leave their jobs? If salaries are better, if benefits are improving, why then . . . ?

The overwhelming reason given is lack of appreciation, not being given credit for the work that is done. Second in line is that they feel they had inadequate training in the first weeks on the job, that they didn't really know what was expected of them, and consequently never were able to perform up to the required level.

They resented being criticized for not performing up to the physician's expectations when they did not know exactly what those expectations were.

Your present office staff can train new people only to a point, the fine tuning must come from you. Just as in a family, you must contribute to the bonding process that provides cohesiveness. You must contribute your energy and your time to change the atmosphere in your office from one of individuals performing tasks, to that of a team working together; a team working for the good of everyone, the employer, the employee, the practice and the patient.

Next Month: "Team Building"

Management Resources,
Dolores Lunstrum

Local News Briefs,
continued from page 6

TACOMA OPTHALMOLOGIST ELECTED PRESIDENT OF THE WASHINGTON SOCIETY TO PREVENT BLINDNESS

Dr. Leonard B. Alenick was recently elected president of the Washington Society to Prevent Blindness. This will be his second term as president of the organization.

DR. SURINDERJIT SINGH SERVES AS EXAMINER FOR AAEE

Dr. Surinderjit Singh was recently asked to serve as an examiner for the American Association of Electromyography and Electrodiagnosis (AAEE). The AAEE examination for active membership was held on May 11 and 12, this year in Chicago.

AT LAST / THE ANSWER TO MALPRACTICE INSURANCE

Reprinted with permission from Dr. F.W. Hennings, the following letter appeared recently in the Tacoma News Tribune headlined, "A Sure Cure for Malpractice Blues."

To the Editor: The article in the paper a couple of weeks ago about an attorney who was acquitted of charges brought against him because he was under the effects of drugs and alcohol gave me an idea that I felt should be passed on to my colleagues. We can now get rid of our malpractice insurance. To those surgeons and gynecologists that may pay from $35,000 to $50,000 yearly, this suggestion should be a boon. Before anyone starts a major surgery they should snort a good amount of cocaine and follow that with a pint or two of booze. Then, if the results are not all that satisfactory, they have an automatic alibi that they were not responsible for their actions because they did not have their full senses.

This advice should also be valuable for truck drivers, locomotive engineers, pilots of passenger planes and others. If an accident occurs, they can use this case as a basis for their defense and it should be foolproof. I must warn you, that right now I am making further inquiries into this matter to see if this ruling only applies to lawyers and not to us common folk.

F.W. Hennings, MD,
75 Bella Bella, Fox Island

LOOKING FOR INFORMATION ON DRGs?

Copies of "DRGs and the Prospective Payment System: A Guide for Physicians" are available from the AMA for $3.50 per copy, including postage. Send your order to: Order Department OP-230, American Medical Association, P.O. Box 10946, Chicago, Illinois 60610.

ON BEING A MILITARY DOCTOR: ITS REWARDS AND FRUSTRATIONS

In the following article Dr. Ray Miller discusses his medical career candidly with Mary K. Tipton, Assistant physician for President Harry Truman. Dr. Miller was featured recently in the "Tacoma News Tribune."

To set the record straight, for all of you who read the article in the "Tacoma News Tribune," Dr. Miller is not the small town boy from Maryville, Mississippi. He is from Maryville, Missouri. An apparent slip of Ed Costello's pen.

—the editor

It was 1959 and Dr. Ray Miller was Chief of Medicine at Valley Forge. It had been a circuitous route, but Dr. Miller was finally where he had asked to be ten years earlier when he graduated from George Washington University Medical School.

Like many, the war years had interrupted Dr. Miller's medical training. 1st Lieutenant in the artillery corps during World War II, he was among those to land on Omaha Beach the day after D-Day. Later promoted to Lieutenant Colonel, he served on General Bradley's staff, seeing action as a line officer in eight major campaigns in Europe, one in Northern Italy.

It didn't take Dr. Miller long, however, to get back to medical school after the war was over. He enrolled in George Washington University Medical School in 1946, completing his training in 1949 with an internship at Walter Reed Army Hospital. Now a 1st Lieutenant in the Medical Corps, he was ready for his residency. But the Korean conflict was beginning and the residency program was suspended. He was sent to Ft. Belvoir, Virginia.

"Simply a parking orbit," he says. He requested an assignment at Valley Forge, but was told Valley Forge was already "manned." Two weeks later he was asked to work with General Wallace Graham, President Harry Truman's physician.

He said he "wanted something to do." He just didn't want to "sit around." While at the White House he had a fellowship in Cardiology and served his residency in cardiology under Dr. Jack Evans. During his last eight months at the White House he was Assistant Chief of Cardiology at Walter Reed.

Dr. Miller remembers his first meeting with President Truman well. He was alone in his office. Dr. Graham was out. The "red" telephone rang (meaning something was hot). The President was on his way down with some kind of "crib cap."

"Dr. Graham didn't tell me what it was," remembers Dr. Miller. "The President was in a hurry. He told me he had a speech to make in 15 minutes. I wasn't sure what Dr. Graham had put on the

President's scalp. The President pulled out a bottle and said, 'this is it.' I dipped my finger into the clear solution, not knowing what it was. When nothing happened to my finger, I figured it was ok for the President's scalp."

One of Dr. Miller's fondest memories while serving as assistant physician for the President was sleeping in Abraham Lincoln's bed. He says even though he stretched and stretched he could not reach the top and bottom of the bed. "But," says Dr. Miller, "it was just right, a good hard mattress."

Remembering President Truman, Dr. Miller says he was very "quick witted, with an amazing memory and a deep love for history. He was very easy going. I never saw him raise his voice or get angry. He was always kind to the little people."

After two years at the White House serving a very healthy President and a happy First Family, Dr. Miller returned for two years residency training at Walter Reed. He then spent one year at the Walter Reed Army Institute of Research.

While there he and 10 other classmates wrote the first draft of the *Technical Medical Bulletin for Management of Mass Casualties*. According to Dr. Miller, the publication not only has application in terms of an atomic disaster, but would also be very useful for any large disaster, such as an earthquake, fire or flood.

In addition, Dr. Miller says he conducted research on the effect nitrogen mustard had on patients with lymphomas when pressure was applied with tourniquets to close off circulation in an effort to protect peripheral bone marrow. At the pressure used, however, Dr. Miller says he found "he was unable to protect the peripheral marrow." Dr. Marcel Conrad published the results of the research after giving larger doses of nitrogen mustard and applying higher cuff pressures.

By 1955 Dr. Miller was off to England as Surgeon of the Anti-Aircraft Artillery Brigade. From England he was sent to Stuttgart, Germany, as Chief of Medicine for the 5th General Army Hospital, where, he says, "he learned to catch beautiful trout."

Then came 1959, Valley Forge and a promotion to Lt. Colonel.

In 1964 while Chief of Medicine at Madigan, Dr. Miller was sent to Vietnam to command the 44th Medical Brigade. "It was the only medical brigade ever put into the field," says Dr. Miller. Responsible for an entire brigade of 128 units which included surgical hospitals, evacuation hospitals, field hospitals, convalescent hospitals and the army supply system, Dr. Miller says he soon learned the fine art of "back channel maneuvering."

According to Dr. Miller, most of the physicians were trained in very good hospitals where they had the equipment they needed. When they got to Vietnam, however, this was not necessarily the case. There was a great deal of frustration.

For example, says Dr. Miller, "We had no Fogarty catheters or defibrillators. We did a lot of back channel maneuvering," he says. "Sometimes it would take a month, sometimes three months to get something we needed. Sometimes we never got it."

Without stationary hospitals, however, according to Dr. Miller, it would have been even more difficult, if not impossible to get the necessary equipment for proper medical treatment.

Dr. Miller remembers Vietnam as a time of immense responsibility. With 36 helicopters under his control, medical units under his command were spread over the entire area. "The surgeons," Dr. Miller says, "handled more trauma than most see in a lifetime.

"We were faced with new diseases all the time. Malaria and pungi stick wounds were tremendous problems. At one time," says Dr. Miller, "we had 2,000 down with malaria in the convalescent hospital.

"We treated the tropical disease, meloidosis, many times, with no success. We tried every antibiotic we had available. Nothing worked.

"We had a great fear of the plague, especially pneumonic plague. We had 18 cases break out at Camranh Bay." According to Dr. Miller, to prevent the spreading of plague the medical corps trapped and killed rats and sprayed.

Lives were saved in Vietnam, according to Dr. Miller, because hospital units were permanent, there were dust tight operating rooms and medicine in general was more advanced.

As for the future in medicine, Dr. Miller sees medicine more technical now with tremendous benefits. "But at the same time," he says, "medical costs are going up. Medicine has become more expensive, and the subspecialities have influenced the face of medicine."

Primary care physicians are losing control, in part, Dr. Miller thinks, because of competition among physicians. "Patients are referred to subspecialists, but the patient is occasionally not referred back to the primary care physician," says Dr. Miller. It is, he says, an ethical question that will impact the way medicine is practiced. ■

MEDICAL DISCIPLINARY BOARD HELPS TO MAINTAIN INTEGRITY OF MEDICAL PROFESSION

By Richard T. Vimont, MD

The creation of a medical disciplinary board for the purposes of protecting public health and safety and maintaining the integrity of the medical profession was a logical sequel to medical licensure. The WSMA supported the creation of the board in 1955 and has demonstrated its continuing interest by establishing a disciplinary task force. By improving communication and cooperation this will help to accomplish the purposes of the board. Maintaining the integrity of the medical profession is in the best interest of physicians and patients. Your recent bill from the state for $30 annual disciplinary assessment will help to support the Medical Disciplinary Board in its efforts.

Additional funding for the activities of the board has been provided by the creation of the new medical disciplinary account. While this is an account within the general fund, all assessments, fines and other funds received pursuant to this chapter are to be deposited in this account and used to administer chapter 18.72 *Medical Disciplinary Board*.

With increased funding there should be an increase in staff to more rapidly process cases for board consideration and to better monitor physicians upon whom restrictions have been placed. Increased funding also necessitates careful budget review and cost/benefit consideration of any proposed new or expanded board or staff activities. The increased funding to accomplish the purpose of the board is essential. Increased activity based on the increased funding and having a high cost/benefit ratio is to be avoided.

Members of the board and staff are now meeting with members of county medical societies and the WSMA task force in order to establish a better understanding and a closer working relationship with the professional community. This should lead to a cooperative effort resulting in early identification of physicians who are impaired, conducting an unsafe practice or guilty of unprofessional conduct all of which reflect on the quality of medicine and the integrity of the medical community.

With the help of local physicians evaluation of those under investigation will be much more adequate and monitoring of those upon whom restrictions have been placed will be much more effective. Help for impaired physicians both in conducting reviews and in rehabilitation programs are best carried out with the participation of local specialists.

The board is composed predominantly of licensed physicians representing a wide spectrum of practice. This is essential since it is the only group which has had experience both in the practice of medicine and as a member of the public sector.

Public safety is the guiding consideration of the board when charges are heard and conclusions are reached. The board then has wide discretion if guilt has been established. Revocation of license is ordered if this is considered to be the only way the public can be protected and the integrity of the medical profession preserved.

Restrictions with monitoring are often appropriate. Sometimes a censure or reprimand is considered sufficient. In many cases suspension or restriction while a rehabilitation program is in progress results in a return to full practice.

A number of impaired physicians have expressed their gratitude to the board for taking action that has necessitated their participation in rehabilitation programs which have enabled them to return to practice as respected members of the medical community. This is also one of the pleasant aspects of serving on the board.

A very brief overview of the law relating to the medical disciplinary board seems appropriate at this time.

The board is an administrative agency of the State composed of a licensed physician from each congressional district

continued on next page

Medical Disciplinary Board Maintains Integrity of Medical Profession, continued from previous page

elected by his or her peers, a public member appointed by the governor and in addition the director of licenses or his designee who serves as an ex-officio non-voting member.

An executive director is appointed by the director of the department of licensing from a list of three names submitted by the board. The director must also employ such additional staff as required to enable the board to accomplish its duties and responsibilities. The attorney general is the advisor of the board and represents it in all legal proceedings.

It is the duty of the board to investigate all reports of unprofessional conduct against any licensed physicians and to hold hearings to determine if unprofessional conduct has been committed. Reports of malpractice and unsafe conditions and practices must be investigated. Equipment, procedures and training in such cases are analyzed and corrective action taken. In extreme cases the board has the power to order a summary suspension of the license of a physician or to restrict his practice pending proceedings by the board.

Unprofessional conduct as defined by Washington law includes a wide variety of offenses. These range from moral turpitude, dishonesty, or corruption, whether committed in the course of medical practice or otherwise and whether the same constitutes a crime or not through gross, wilful, or continued overcharging for professional services.

Some of the other items covered are criminal abortion, concealment of a material fact when obtaining a license, deceptive advertising, possession, use or prescription of controlled substances or legend drugs for non-therapeutic purposes and incompetency or negligence in practice resulting in serious harm to the patient.

Additional items covered in the definition are impersonation of another licensed practitioner, suspension or revocation of the physician's license in another jurisdiction, use of secret treatments with refusal to divulge details to the board, acceptance of "kickbacks" and aiding or abetting an unlicensed person to practice medicine.

Violation of board regulations fixing a standard of professional conduct, failure to cooperate with the MDB and failure to abide by the terms of corrective action specified by the board are also included in the definition of unprofessional conduct.

If the board determines that there has been unprofessional conduct or unsafe practice by a licensee the appropriate

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AUXILIARY NEWS

HEIDI BECK, ERIC ANDERSON WIN STUDENT RECOGNITION AWARDS

Each year the Medical Society of Pierce County takes pleasure in recognizing an outstanding senior son and daughter of a physician who is a member of the Society. Based primarily on scholarship, this award also includes leadership and service to school and community.

Students who applied for this award were remarkable in every way, and it was a pleasure for the committee to review the candidates. The medical community deserves to be proud of these high school graduates.

The Student Recognition Selection Committee congratulates Heidi Beck and Eric Anderson, recipients of this year's award.

A graduate of Charles Wright Academy, Heidi Beck is the daughter of Dr. and Mrs. Ronald J. Beck. Along with her many scholastic credits, Heidi has experienced a unique academic and cultural career during her high school years, including attending a Swiss high school and working a summer with India's youth training program. She plans to attend Harvard University in the fall as either an English or pre-med major.

Eric Anderson, a graduate of Lakes High School, is the son of Dr. and Mrs. Charles Anderson. Eric has accepted responsibilities in a variety of school and community activities during the past four years. An outstanding scholar and athlete, Eric plans to attend the University of Washington or Pacific Lutheran University next fall with pre-med as his major field of interest.

This has been a busy May as president Gloria Virak has seen a successful year as PCMSA president come to an end. Gloria sends her thanks and appreciation to all of you for your support this past year.

NOTICE

Membership chairman Marilyn Bodily asks that all addresses or telephone number changes be submitted to her by August 1, 1984 to be included in the membership book.

DR. TOM IRISH DISCUSSES COSMETIC SURGERY

May 18 was the date of the last luncheon meeting of the year, held at the exquisite home of Sharon Lakens. Dr. Tom Irish presented a fabulously entertaining and informative program on cosmetic surgery. We all hated to have the afternoon come to an end.

ALICE HILGER, JO ROLLER, CINDY ANDERSON ELECTED TO STATE BOARD FOR WSMSA: ANDERSON RECEIVES $50 HONORARIUM

Alice Hilger, Jo Roller, and Cindy Anderson were elected to the State Board for the Washington State Medical Society Auxiliary. Alice Hilger was elected Co-chairman of the Organ Donation Committee. Jo Roller will serve as Chairman of the By-Laws Committee and Cindy Anderson is Vice President of Southwest Region for WSMSA. Cindy Anderson also received a $50 AMA-ERF honorarium, donated to medical research in her name, for designing a delightful, 16 page coloring book featuring cartooned health and safety hints. (Congratulations, Cindy!)

PCMSA WINS AWARD FOR LARGEST CONTRIBUTION TO AMA-ERF

A few things you can be proud of department! Pierce County won the award for the largest contribution to AMA-ERF in the state. Donations added

continued on page 17

Auxiliary News, continued from page 16

up to a grand total of $14,485.52. We also won the award for having the highest dollar amount per capita — $65.55.

President Gloria Virak received the following letter in response.

Dear Mrs. Virak,

Thank you for your auxiliary's recent contribution to the School of Medicine. This gift helps us to maintain the excellence of the teaching and research programs of the school and to give our students a quality medical education. On behalf of the students, faculty and staff of the School of Medicine, I would like to thank the members of your auxiliary for their generous support.

Sincerely,
David D. Dale, MD, Dean

Have a sunny summer!

—Janet Fry

WASHINGTON STATE MEDICAL ASSOCIATION AUXILIARY CONVENTION HELD

The WSMAA Convention was held the first week in May at Lake Quinault, a relaxed, rustic setting. The spring meeting is the business session for the state organization. Convention highlights included the election of state officers for 1984-85, election of Nominating Committee, reports on state health projects, reports from Leadership Confluence and awards.

An increase in state dues was discussed and postponed until next year.

All convention participants took part in a creativity workshop which allowed us to identify our own strengths and weaknesses in the area of creative thinking.

Pierce County delegates were: Gloria Virak, Ginnie Miller, Helen Whitney, Nikki Crowley, Norma Lloyd, and Sharon Ann Lawson. State Board members attending the convention were: Cindy Anderson, Alice Hilger, Jo Roller, and Nancy Spangler.

I encourage all of you to consider being a delegate to our State Convention. Please contact me if you are interested.

—Sharon Ann Lawson

NOTICE

Pictorial Directory Change

Wagonfield, James B., phone number should be 564-3789.

Medical Disciplinary Board Maintains Integrity of Medical Profession, continued from page 15

sanctions are imposed to protect the health and well-being of the people of the state and maintain the integrity of the medical profession.

There is also provision for dealing with the impaired physician who cannot adequately conduct his practice. His license can be suspended or conditions may be imposed on the conduct of the physician's practice as are appropriate for the protection of the public. A physician affected under this section must at reasonable intervals be given the opportunity to demonstrate that he or she can resume the competent practice of medicine.

continued on page 19

PRESCRIPTION DRUG ABUSE: AN INTERPROFESSIONAL PROBLEM

The following article, as stated in this month's News Briefs, will be Dr. Judd's last one. The membership will miss Dr. Judd's reporting of the Committee's activities. His articles are educational, readable and enjoyable.

Along with pharmacists Fred Dean and Don Herbert, Drs. Judd, Dan Thomas and George Race were the first members of the committee when it was formed nearly 25 years ago. At the time they used to meet in committee members homes.

The close relationship between physicians and pharmacists in Pierce County is a result of this Committee's efforts to improve the communication between the professions.

—the editor

According to the encyclopedia, drugs are substances, other than foods, which, when taken into the body cause a change in it. If the change helps the body, it is a medicine; if the change harms the body, it is a poison. We all know that the drugs we prescribe can be helpful or poisonous, depending on their method of use.

The abuse of drugs is creating an ever increasing problem in the health care of Americans and, indeed, people world wide. This has prompted the American Medical Association to create committees to study and deal with this problem.

Did you know 60 percent of emergency room visits nation wide for drug abuse were for drugs prescribed by a physician, and 70 percent of drug related deaths were attributed to the same source?

Who of us as physicians is responsible—the doctor who overprescribes? The pharmacist who overdispenses? The rare but occasional doctor who is dishonest and does it for profit? The disabled doctor who doesn't realize he is making a mistake? The duped doctor who believes a convincing story (and we all know how convincing they can be) and prescribes a controlled substance for the patient whose doctor is "out of town until next week" or "he told me to call you if I ran out and needed more while he is on vacation."

Sometimes it is the doctor who leaves his prescription pad where a patient can rip off a few sheets in the examining room while he is waiting. Sometimes it is the thief who breaks into the office at night. And sometimes it is the drug, often heroin or cocaine smuggled into the United States from a foreign source. Not all of these are apprehended by a long shot, no matter how hard our authorities try.

According to a survey taken by the AMA panel on drug abuse, tranquilizers constituted the largest percent of abused prescribed drugs. Narcotics were second. It is hard to imagine, but over $16 billion were spent in the United States in 1977 alone for the results of drug abuse and of these, crime related to drugs cost over $4 billion. 831 million died in 1977 from drug abuse! Each of us should review the AMA eight guidelines for the prescription of controlled substances. It would do us all a lot of good.

The effects of tobacco smoking will not be dealt with here for the sake of brevity, but the statistics are equally alarming and may be reported in a subsequent article. Suffice to say, your Interprofessional Committee spent another two hours in lively discussion, starting at 7 a.m., Wednesday, May 2. The Committee will continue to meet quarterly.

continued on page 19

Prescription Drug Abuse: An Interprofessional Problem, continued from page 18

Any problems or suggestions you have will be given every consideration if you will present them to me, preferably in writing, so I won't forget what your concern was.

Incidentally, did you know that prescriptions for patients being treated on State Industrial Insurance must bear your state I.D. number as well as the code number for the injury or illness of the patient being treated?

And a last reminder: there has been a change in the method of assaying Synthroid so that the new method reflects 100 percent of the drug's activity, not 80 percent. If your patient gets "jumpy" you might want to reduce the dose!

And yes, the Hot Line is still working! So if you lose prescription blanks or suspect a patient is trying to get controlled substances from you, call your friendly pharmacist. He can help you!

Herman Judd, MD

Medical Disciplinary Board Maintains Integrity of Medical Profession, continued from page 17

Please keep in mind that the board can only act on substantial evidence indicating unsafe practices, unprofessional conduct or physician impairment to the point of being unable to adequately conduct his or her practice.

For a copy of the actual law refer to Chapter 18.72 of the *Revised Code of Washington*.

While any person, firm, corporation, or public officer may submit a written complaint to the board, mandatory reporting at this time is required by the following:

Health Care Institutions
Medical Associations or Societies
Health Care Service Contractors and Disability Insurance Carriers
Professional Liability Carriers
Courts
State and Federal Agencies
Professional Standards Review Organizations

Some of these organizations are required to report to the disciplinary board when a physician's privileges are restricted due to unprofessional conduct, incompetence or upon becoming impaired. Others report because of overcharging, overutilization or fraud.

Professional liability carriers report malpractice settlements over $30 thousand or three or more claims paid in one year. The information disclosed in mandatory reports is kept for the confidential use of the board and is not subject to subpoena or discovery proceedings in a civil action suit and is exempt from public disclosure except that it may be reviewed by the licensee or his counsel and a representative or investigator of the MDB. In the near future a public hearing will be scheduled concerning the addition of *Mandatory Reporting of Physicians by Physicians*.

A booklet, "*Mandatory Reporting and Disciplinary Guidelines*," issued by the department of licensing, covers the mandatory reporting regulations through 1983 and also gives pertinent portions of RCW Chapter 18.72.

Inquiries or complaints should be addressed to: Department of Licensing, Division of Professional Licensing, P.O. Box 9649, Olympia, WA 98505, ATTN: *Medical Disciplinary Board*. Phone: (206) 753-2205 or 753-3779.

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CLASSIFIED

Northeast Tacoma Professional Center—Great Location above Brown's Point. New professional office space. Two blocks from Jr. High. Energy efficient. Full basement for mechanical and storage. Interiors to suit. Super competitive leasing terms. This great community needs a medical office. Dennis/Jean (206) 272-2713.

For Lease—Quad Professional Building, 1st Ave. S. and S.W. 330th, Federal Way, WA. New 3-story building for Medical/Dental professionals, ready for your tenant improvements. Ownership available through lease terms. Call today for more information. Mike Miller, 244-5706 or 284-7343 (evenings). Portal West Realty.

For Sale—Office equipment to set up new office, including exam room and office furniture. Call: 584-1911.

Gig Harbor Practice Opportunity—Fully equipped medical office at Harbor Park Professional Center. Available for immediate occupancy. 1,080 square feet of space with top quality equipment. Ideal for primary-care or share with other sub-specialist. Call (206) 851-5578 for details.

GP Retiring—Walk in and take over. Reasonable terms. Beautiful Mt. Vernon, 3 blocks from hospital. 428-2626, day or night.

Medical Building for Sale in the Sea-Tac Medical Center, Federal Way. 2,079 sq. ft., includes 3 exam rooms, lab and physicians' office with private entry. Room to expand in daylight, lower level. $195,000. Contact Mike Miller, 244-5706 or 284-7343 (evenings). Portal West Realty.

Lakewood General Practice Opportunity—Lease the space: start practice with many referrals. Call: 473-7303.

Office Sharing Opportunity—Dr. Charochak seeking another physician to share office space with her, 2 to 3 days a week in new Puyallup Office. Call now to participate in planning of office to open late summer. Terms negotiable 848-5555 or 582-7477.

For Sale: Medical Practice—Suburban Tacoma, 1,600 sq. ft. Two large examining rooms, minor surgery, X-ray and lab. Phone 537-8656, P.O. Box 44488, Tacoma.

View Home—Gig Harbor: Now $120,000 by owner. I've slashed $16,000 off the price on this 2,800 sq. ft., 3 bedroom home with many amenities. Must sell by summer before mortgage rates climb to 15%. Call George: 1-851-5248.

Privacy-Plantings-Pool—Country-like setting. 1⅓ acres on Lake Steilacoom Dr., beautifully landscaped, enclosed. Charming home: 4-bedroom, 3½-bath, single-level, hardwood floors and carpeting, 2 fireplaces, with 2-car garage. Lease at $1,350, negotiable. Call 584-4417.

Gig Harbor Home for Sale—1-year-old, 4 bedrooms, 3 baths, oak spiral staircase, formal dining, split level master bedroom with 3-car garage, 2,400 sq. ft., Mt. Rainier view, 1½ acre wooded lot, ½-mile from golf course, 8 minutes from Narrows. By owner, 627-6547 days, 1-851-6714 eves.

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SAN FRANCISCO VICTORIAN. Three-bedroom, 2-bath home in the fantastic Seminary Historic District. Much restoration and remodeling, including huge excellent kitchen, new masonry fireplace, roof, wiring, etc. Superior investment in North Tacoma. $79,500.

DUTCH COLONIAL. Beautiful North G Street, 3-bedroom, 2½ bath home, with many vintage features. Some marine and mountain view. Excellent parking in rear of property for RV or large boat. Assumable mortgage balance of $81,000 at 11½%! $89,900.

ENGLISH STYLE, VIEW! Large and beautiful home with 4-plus bedrooms, 4 baths. Especially memorable features: stunning wrought iron staircase; rich, brocade plaster work in entry hall and living room, accented with handsome wall scounces. Excellent marine view from living room and master bedroom. $165,000.

FRENCH PROVINCIAL. Rich and graceful with arched French doors, curved open staircase, exquisite fireplace and richly paneled library. 4 or 5 bedrooms, 4 and ½ baths, family room with bar, billiard room. Over 5,000 sq. ft. of function and elegance. Security System. $230,000.

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State Seeking Review Positions in Olympia

The Washington Office of Disability Insurance is seeking physicians in the psychiatric field to review medical evidence and disability claims under the Social Security and Supplemental Security Income programs. *Physicians are asked to commit a minimum of 20 hours per week at our office in Olympia.*

Payment is according to the Washington Consultative Physician's schedule. Orientation to the disability program and office space will be provided.

Interested physicians are asked to contact *Eleanor E. Giffin, M.D.*, Chief Medical Consultant, or *John E. Peters*, Professional Relations Manager, Office of Disability Insurance. They can be contacted on a toll-free line **1-800-562-6074** or at the following address:

Office of Disability Insurance
P.O. Box 9303
Olympia, Washington 98504

An added complication... in the treatment of bacterial bronchitis*

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (Diplococcus pneumoniae), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include: morbilliform eruptions (1 in 100); *Pruritus urticaria* and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

10CS1R

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob Agents Chemother 8:91, 1975
2. Antimicrob Agents Chemother 11:470, 1977
3. Antimicrob Agents Chemother 13:584, 1978
4. Antimicrob Agents Chemother 12:490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy): II:880. Washington, D.C.: American Society for Microbiology, 1978
6. Antimicrob Agents Chemother 13:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr. and J.E. Bennett): p. 487. New York: John Wiley & Sons, 1979

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

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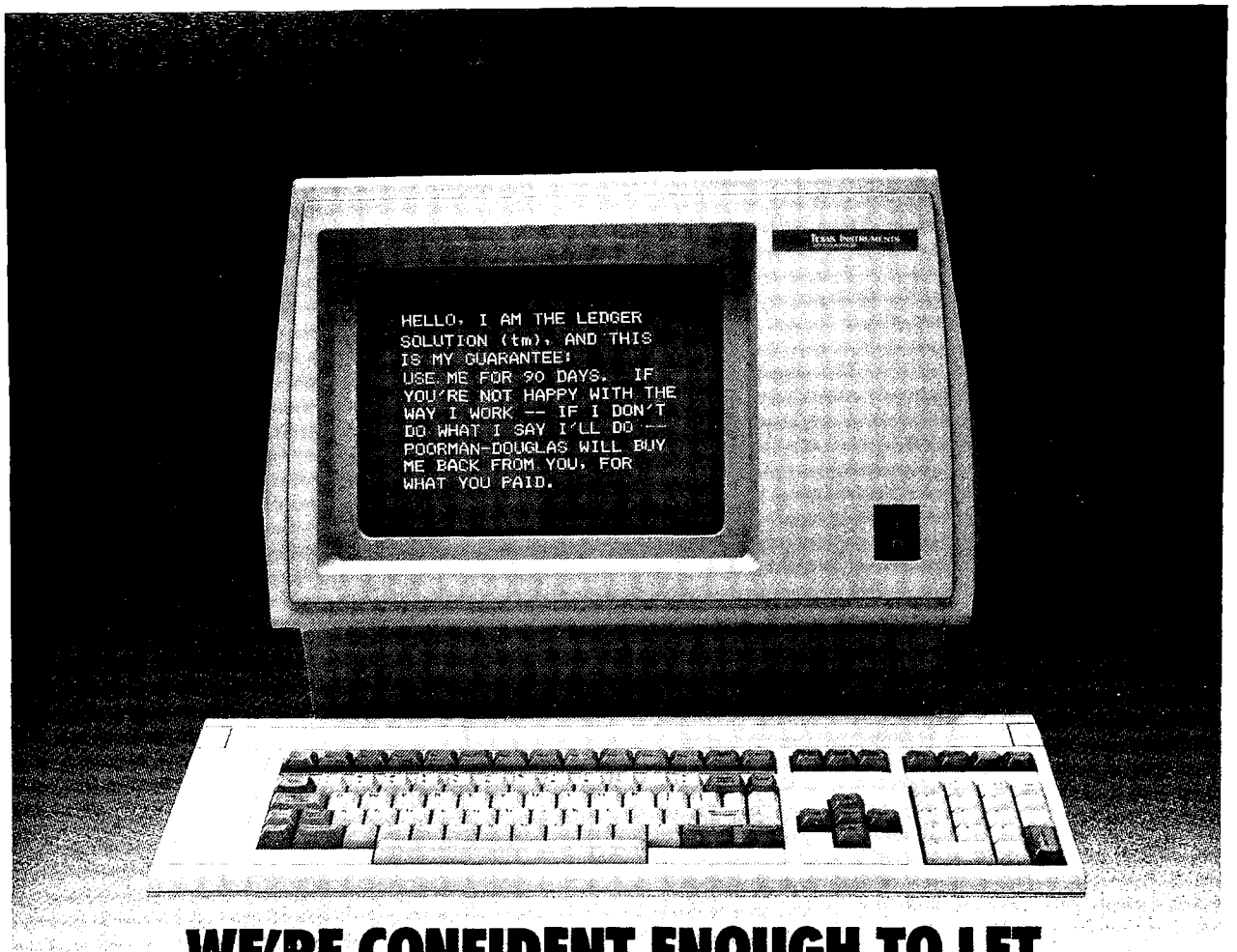
The Bulletin
MEDICAL SOCIETY OF PIERCE COUNTY

August 1984



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The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Cover photo: View of Mt. Everest, 29,028 feet. This months cover photo was taken by Dr. Ben Blackett. For Dr. Blackett's story and other photos see page 12 and 13.

CHANGING YOUR ADDRESS? HAVE A NEW ADDRESS?

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The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Cover photo: View of Mt. Everest, 29,028 feet. This months cover photo was taken by Dr. Ben Blackett. For Dr. Blackett's story and other photos see page 12 and 13.

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

Published Monthly by the Medical Society of Pierce County, 705 South 9th, Suite 203, Tacoma, WA 98405. Telephone: (206) 572-3666. Bulk Rate U.S. Postage paid at Tacoma, Washington. *The Bulletin* is published in the interest of medicine and allied professions. The opinions herein are those of the individual contributor and do not necessarily reflect the official position of the Society unless so stated. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. *The Bulletin* and the Medical Society of Pierce County reserve the right to reject any advertising. Advertising rates may be secured from Val Dumond, Advertising Resources, 2607 Bridgeport Way W., Tacoma, WA 98406, (206) 564-7882. *The Bulletin* is printed in Tacoma, Washington by Lakewood Printing.

President's Page

JOINT VENTURING

In September 1983, the House of Delegates of the Washington State Medical Association passed Resolution #9, sponsored by Dr. Lloyd Elmer of Pierce County. This resolution committed the WSMA to participate in funding a pilot project to determine ways in which physicians and hospitals might work more closely together for mutual benefit in this new, competitive era. In addition, it recommended that results of such a pilot project be used to determine the feasibility of establishing a state-wide corporation for further development of appropriate organization.

During the ensuing months, an *ad hoc* steering committee was appointed by the Medical Society, chaired by Dr. Ralph Johnson, to pursue this project. We have held a number of meetings on the subject. Several of our medical and hospital representatives attended a two-day symposium in Minneapolis, hosted by the Hennepin County Medical Society, to help organize our thoughts and ideas about ways to start this project. Since this April 1984 symposium, our committee has had an opportunity to discuss directly with the Executive Director of that Society the appropriate response for physicians in Washington State.

We have agreed to make available to hospital medical staffs and hospitals the MeSH Central concept and its related working papers. The Medical Society of Pierce County therefore recommends that:

1) The plan for state-wide or county-wide incorporated medical staff organization is not practical as outlined in Resolution #9.

2) WSMA purchase the Hennepin County "model."

3) WSMA assist in organization of Physicians Associations in medical staffs of interested hospitals.

4) Pilot projects be established in Pierce County, preferably in one small community in Tacoma.

5) WSMA distribute the Hennepin County "model" to members at the lowest possible cost.

6) WSMA make the "model" available for study and review by county Medical Society members prior to the purchase.

7) WSMA support the MeSH Central concept to prevent further weakening and fragmentation of the medical community.

These recommendations will be forwarded to the WSMA Executive Committee, where they will be reviewed and discussed. Hopefully, by the September 1984 WSMA state convention, some small project related to the recommendations will be in operation. It appears at present that an "after hours" clinic, located in one hospital and staffed by a private physicians' organization, will be functioning in July. There is also a possibility that two such clinics may be active before the September convention.

I give special thanks to Dr. Ralph Johnson and his *ad hoc* steering committee for the important task they have accomplished. No doubt some of you do not yet understand the MeSH Central concept, and did not have the privilege of hearing Dr. Jack Wood and attorney, Paul Elwood, who articulated this concept at some length at our 1983 annual meeting. Please, for your sake, take the time and energy to read about this new concept of the practice of medicine which appears on the horizon.

—JPD

Local News Briefs

MEDICAL SOCIETY MEMBERS TAKE ACTIVE PART IN SOUND TO NARROWS FUN RUN

An estimated 12,000 runners challenged the gruelling, but scenic, 7.8 mile course through Point Defiance, to take part in the 12th annual Sound to Narrows Fun Run.

Members of the Medical Society participated from start to finish. Drs. Mark Jergens, Eric Platz, Matt Rice, and Paul Seward played a big role in developing an organized emergency medical system for the day. They sat in on several committee meetings with other emergency services personnel at the News Tribune to coordinate emergency treatment for the runners.

A nice breeze at the beginning of the run kept the number of casualties down. The doctors in the medical tent reported a busy day, but they were well prepared, and only one runner had to be sent to the hospital.

Meanwhile, out on the course, Dr. Ron Taylor placed 8th in the 40-49 age category with a very admirable time of 46:54. Some of the other doctors and auxiliary members on the course who enjoyed the "fun" run were:

Ron Taylor
Ron Anderson
Suzanne Annest
W. Brandt Bede
Ron Beneviste
Stephen Bergmann
Verna Bergmann
James Billingsley
Karen Bloustine
Stan Bloustine
Richard Bowe
Bruce Buchanan
Robert Ettlinger
Jim Foss
Janet Fry
Ken Graham
Jim Griffith
Sandra Griffith
John Hautala
Sam Insalaco
Karen Knight
Richard Knight
James Komorous
Hugh Larkin
Cindy Lenihan
John Lenihan, Jr.
Garth McBride
Jan McIlroy
John McKelvey, III
Jack Nagel
Don Pearson
Mike Priebe
Barb Przasnyski
Bruce Romig
Craig Rone
Alan Tice
Jan Torgenrud
Terry Torgenrud
Keith Tucker
Dennis Waldron

If a member, or an Auxiliary member, participated in the "Run" and was not listed, please call the Society office and corrections will be run in the September issue.

The Auxiliary Membership Committee would like to know about any new members in our medical community. We would like to include the spouses in our newcomers activities. Help us keep our list up to date by calling one of the following auxilians:

Bev Graham	752-3457
Alice Wilhyde	572-6920
Sandy Shrewsbury	1-265-3050
Sharon Ann Lawson	564-6647

Local News Briefs, continued on page 6

FYI: CORRECTIONS FOR YOUR PICTORIAL DIRECTORY

The following is a list of further corrections for your Pictorial Directory that did not appear on the amendment sheet.

The pocket sized Directory of Pierce County Physicians and Surgeons is scheduled to be published in September. All physicians who did not submit corrections and/or changes will appear as they did in the 1983 Directory.

If you need to verify how your data will appear in this Directory, call Membership Benefits, Inc., at 572-3709.

Page #	Doctor's Name	Correction
2	Annest, Leonidas	Address: 1207 S. 5th St.
12	Bergstrom, Wayne A.	Home Phone # 564-7900
16	Buttorff, Douglas P.	Retired
20	Conte, William R.	Home Phone # 964-1017
28	Giombetti, Carl A.	Relocated
32	Houtz, Dudley W.	Office Phone # 594-1087
34	Kanar, Edmund A.	Home Phone # 472-1520
36	Kitazawa, Margaret	Relocated
36	Klatt, Gordon R.	Address: 902 S. "L" St., # 202
41	Martin, William H.	Address: 902 S. "L" St., # 202
52	Rone, Craig	Address: Suite 110
52	Roth, Rob R.	Office Phone # 594-1043
54	Saeed, Mohammad A.	Address: 1901 S. Cedar # 302
54	Sakakini, Joseph Jr.	Relocated
56	Singh, Surinderjit	Address: 1901 S. Cedar # 302
58	Steinitz, Edgar S.	Address: 1901 S. Cedar # 302 Physical Medicine Rehabilitation and Electrodiagnosis
58	Stilwell, James R.	Office Phone # 627-8757
61	Wagonfeld, James B.	Home Phone # 564-3789
62	White, Alan P.	902 S. "L" St., # 202
64	Wohns, Richard N.W.	Middle initials N.W. Office Phone # 383-4379 Home Phone # Unlisted
64	Wulfestieg, Carl	Name Spelling: Wulfestieg
65	Zimmermann, Herbert, Jr.	Relocated

TACOMA–PIERCE COUNTY HEALTH DEPARTMENT OFFERS DIABETIC PROGRAM

The Tacoma-Pierce County Health Department's Home Health Services has a diabetic program to help provide continuity of care for diabetic patients. All services are given under the direction of the patient's physician.

With community health nurses available to meet the patient and family in their own home and provide teaching and monitoring, the Health Department's Home Health Services goal is care and support that promotes optimum health and maximum independence.

Skilled nursing services assess physical, emotional and environmental needs of the patient and family, and plan of care is established. The patient and family are taught home care that encourages independence. The patient's blood sugar can be monitored with a glucometer. Patients are observed and evaluated for any significant changes in condition with regular reports to their physician.

In addition, physical and occupational therapy, speech therapy, community health aid and nutritional consultation are available through the Health Department's Home Health Services.

Fees are based on costs for services and may be covered by Medicare, Medicaid, private insurance, or a sliding fee. For further information call Home Health Services, 591-6485.

COY HOWARD RECEIVES ST. JOSEPH HOSPITAL'S FIRST NURSE OF THE YEAR AWARD

The first St. Joseph Hospital Nurse of the Year award was presented to Coy Howard, RN as part of the National Nurses' Day reception at the hospital.

Howard was selected from a field of outstanding candidates who were nominated by co-workers.

Howard has worked at the hospital since April 1981 and is currently working in the Coronary Care Unit. She received certification as a Coronary Care Registered Nurse in September, 1983.

"I'm very honored at the distinction," Howard said. "There isn't a day that passes that I don't get recognition from my co-workers at being named St. Joseph Nurse of the Year; it's a wonderful honor and a most generous award," she concluded.

The award program was developed as a result of the wishes of Mr. & Mrs. George Lagerquist. Mr. Lagerquist is a member of the hospital's board of trustees and president of the St. Joseph Hospital Foundation for Community Health. It is their

These are the rules:

Local News Briefs,
continued from page 6

hope that the award will give recognition for and inspire development of the highest levels of nursing skills and professionalism.

Howard received a trip for two to Papakea Beach Resort in Maui, Hawaii for being named Nurse of the Year.

PUGET SOUND COLLECTIONS, INC. SPONSORS MEDICAL CREDIT AND COLLECTIONS WORKSHOP

Puget Sound Collections, Inc.* sponsored a Medical Credit and Collections workshop at the Sheraton Hotel, Thursday, June 21, 1984. Principle speakers included Mr. John Grimm, certified instructor for the American Collectors Association and Mr. Keith Oberhansley, Chapter 13 Trustee for the United States Bankruptcy Court.

The workshop was enthusiastically received as participant comments below reflect. Mr. Frank Rossiter, president of Puget Sound Collections, has indicated that a fall workshop will be announced soon for those who were unable to attend due to the large response for registration.

Participant Evaluatory Comments:

"Excellent presentation of valuable material"
"Handouts are excellent"
"Enjoyed the sharing of information"
"Legal overview was most informative"
"Would appreciate more workshops"
"Very fine program—the best I can remember attending"
"I learned a great deal"
"Very useful information"
"Exchange of ideas from the audience very helpful"
"Please continue to offer these educational opportunities"
"Best medical collection workshop I have ever attended"
"Very, very good"
"Excellent speakers, good material"

* *Puget Sound Collections is an endorsed service: Medical Society of Pierce County.*

MSPC PROFESSIONAL RELATIONS COMMITTEE

Your colleagues want to help

Medical Problems
Drugs
Alcohol
Retirement
Emotional Problems

Members of the Professional Relations Committee for physicians

William A. McPhee 474-0751
Patrick Donley 272-2234
Ronald C. Johnson 841-4241
Jack P. Liewer 588-1759
Robert A. O'Connell 627-2330
Dennis F. Waldron 272-5127

MEDICAL SOCIETY SUPPORTS BOARD OF HEALTH RESOLUTION ON SMOKING BAN

Smoking in enclosed public places and the workplace continues to be a priority issue with the Society. The Public Health/School Health Committee, under the chairmanship of Dr. Terry Torgenrud has brought the issue before the City and County Councils, with the help of the American Lung Association of Washington, FANS (Fresh Air for Non-Smokers), and the Tacoma-Pierce County Health Department, under the direction of Dr. Nicola.

As reported in the May *Bulletin*, Dr. Alan Tice's testimony before the Tacoma-Pierce County Board of Health put the controversial issue before the City and County Councils.

Dr. Tice and Dr. George Weis have appeared before the councils urging adoption of the ordinance drafted by the volunteer groups. The only organized opposition to date has come from the Restaurant Association and tobacco interests.

The crux of the proposed ordinance is that it provides for designated smoking areas rather than designated non-smoking areas. This is more attuned to national statistics, that only about 31% of the population smokes. It is patterned after the Minnesota Clean Indoor Air Act and the San Francisco Smoking Pollution Act.

Future meetings are scheduled with the individual councils, before public hearings are scheduled. Members of the PH/SH Committee have met with the Legislative Committee of the Chamber of Commerce to allay the business community's fears that the ordinance would be prohibitively expensive and unenforceable.

To help determine its attitude towards the smoking issue, the Society conducted the following Opinion Poll of its membership. Results of the survey published on this page reinforced the Board of Trustees' decision to take the issue before the councils.

Results of Medical Society Opinion Poll on the Smoking Issue

		YES	NO	
a) Do you smoke cigarettes?	7%	26	355	93%
b) Do you believe the Medical Society should take a public stand against smoking?	94%	356	23	6%
c) Do you believe there should be a portion of every public place reserved for no smoking?	91%	340	34	9%
d) Do you believe a non-smoker should have the right to prevent others from smoking in his work area?	92%	335	30	8%
e) Do you believe smoking should be completely barred in hospitals?	74%	279	96	26%
f) Do you think more efforts should be made in our schools to emphasize the negative effects of smoking?	95%	359	96	26%
g) Do you think the distribution of free cigarette samples should be prohibited?	81%	301	71	19%
h) Do you think cigarette machines should be restricted to areas where minors are prohibited (bars, taverns)?	72%	267	105	28%
i) Do you think public advertising of tobacco products should be prohibited?	64%	234	132	36%
j) Are you willing to speak to public groups about the hazards of smoking?	42%	150	203	58%
k) Other comments				

BREAST FEEDING PROGRAM HELPS PROMOTE SUCCESSFUL NURSING

By Gail Brandt

For Marilyn B., the Breastfeeding Program was just what the doctor ordered. She was having difficulty getting her baby to nurse. He fussed so much and she was getting very discouraged about breastfeeding. She called her physician who referred her to the Breastfeeding Clinic at the Tacoma-Pierce County Health Department.

The Lactation Specialist corrected the mother's positioning of the baby at the breast and explained the nipple confusion resulting from early introduction of a supplemental bottle. Marilyn B. is very satisfied that she can now easily breastfeed her baby.

Tami S. was referred to the Breastfeeding Clinic by the hospital nurse because of her extremely sore and painful nipples. The Lactation Specialist consulted with her over the telephone, suggesting some specific treatments and positioning changes. There was some improvement, followed by a visit to the Breastfeeding Clinic at which time the problem of sore nipples was completely resolved.

These are just two (2) examples of the Health Department helping to promote successful nursing. Since February 1984, the Breastfeeding Program has provided services to pregnant and breastfeeding mothers to increase the rate and duration of breastfeeding, especially among low income women.

Monthly educational classes are taught at the Health Department by Sandra Jolley, PNP, Lactation Specialist. Mothers will receive basic "how to" information as well as prevention and correction of difficulties sometimes experienced during nursing.

First time mothers, those who have not been successful in the past and women who must return to work or school while continuing to breast feed, are encouraged to attend. However, all pregnant and breastfeeding women are welcome to attend. There is no charge for the educational classes.

The Breastfeeding Clinic is open two (2) mornings a week to serve nursing mothers who are experiencing difficulties. The clinic is also staffed by Sandra Jolley.

A clinic visit includes a complete history, complete physical exam of the mother's breasts and nipples and the infant, and assessment of the feeding process to correct any positioning or sucking

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MEDICARE CHANGES: IMPACT ON PHYSICIANS

The June 22 edition of the Tacoma News Tribune reported that House and Senate negotiators had agreed on a package of spending cuts that includes a freeze on physicians' fees paid under Medicare.

The agreement includes a 15 month freeze of the fees Medicare will pay physicians, for an estimated savings of $2.9 billion. In addition, the measure includes financial incentives designed to persuade doctors to limit their charges to the amount the Medicare system has deemed reasonable, rather than billing patients for an additional amount.

Under the physician fee freeze, doctors could become subject to penalties if they increased their actual charges to Medicare patients!

The data presented here in Table 1 and Table 2 is from the AMA's Fourth Quarter, 1983, *Socioeconomic Monitoring System (SMS) Survey.* *

Because the changes in Medicare may have different impacts on various segments of the physician population, depending upon location, specialty and other factors, the SMS Survey examines the overall extent of physicians' involvement with Medicare patients and the degree to which this involvement varies among individual physicians.

Physicians' Visits with Medicare Patients

Table 1 presents the average share of physicians' visits that are with Medicare patients. For all physicians, Medicare accounts for just under a third of total visits. This average indicates the importance of the Medicare program as a payor for physicians' services. The shares of Medicare visits are approximately the same for various practice settings. In particular, 26.0 percent of office visits and 30.6 percent of hospital rounds are with Medicare patients.

Table 1 also indicates clear differences among specialties. Medical specialists have over 40 percent of their total visits with Medicare patients, compared to less than 30 percent for those physicians in general and family practice and the surgical specialties. This difference is evident in both office visits and hospital rounds. However, there is little regional variation in the percentage of physicians' visits that are with Medicare patients.

Distribution of Visits by Practice Setting

A report from the federal government on Medicare's prospective pricing system for hospital care stated that the ability of a hospital to respond to prospective pricing incentives would depend on the ability of the hospital administration to transmit those incentives to admitting physicians. If pressures are placed on physicians to change their methods of

continued on page 11

TABLE 1
Average Share of Weekly Visits with Medicare Patients
By Specialty and Region: Fourth Quarter 1983

	Share of Visits with Medicare Patients		
	Total Visits[1]	Office Visits	Hospital Rounds
ALL PHYSICIANS[2]	30.0%	26.0%	30.6%
Specialty			
General and Family Practice	28.0	24.1	28.8
Medical Specialties	42.9	36.7	45.6
Surgical Specialties	25.7	24.4	27.7
Region			
Northeast	33.3	29.0	33.1
North Central	30.8	25.2	31.4
South	27.8	24.8	28.4
West	29.0	25.4	30.5

[1] Includes visits in emergency rooms, outpatient clinics and at all other locations.
[2] Excludes psychiatry, radiology, anesthesiology and pathology.

TABLE 2
Distribution of Visits for Medicare and Non-Medicare
Patients by Practice Setting: Fourth Quarter 1983

	Medicare Patients			Non-Medicare Patients		
	Office	Hospital	Other Settings[2]	Office	Hospital	Other Settings[2]
ALL PHYSICIANS[1]	56.8%	28.4%	4.1%	63.4%	24.6%	0.6%
Specialty						
General and Family Practice	64.5	19.3	10.1	79.6	13.2	1.0
Medical Specialties	44.1	42.3	3.7	53.0	36.5	1.0
Surgical Specialties	64.7	30.1	1.4	65.3	28.4	0.1

[1] Excludes psychiatry, radiology, anesthesiology, and pathology.
[2] Other settings explicitly include nursing homes, convalescent homes, and extended care facilities. The percentage of visits do not sum to 100 percent because visits in the emergency room (ER) are omitted.

**The fourth quarter 1983 survey of the Socioeconomic Monitoring System (SMS) consisted of interviews with 1,202 physicians. The overall response rate was 63 percent.*

Medicare Changes, continued from previous page

practice in a hospital setting, then some shifting in practice settings may occur. The Socioeconomic Monitoring System has therefore begun to collect information on Medicare and non-Medicare visits by type of setting, in order to monitor any possible changes that may occur in the future.

Table 2 indicates that for all physicians 56.8 percent of Medicare visits are in the office, while 28.4 percent are in the hospital. However, physicians in the medical specialties have a substantially higher proportion of their Medicare visits in a hospital setting than do other physicians. This comparatively high percentage may suggest that physicians in the medical specialties will be more likely than other types of physicians to be affected by pressures created by DRGs. At present, these patterns of visits by practice setting are similar to the pattern displayed by non-Medicare patients.

Breast Feeding Program, continued from page 9

problems. Close contact will be maintained with the mother's primary physician.

There is one annual charge for clinic visits based on a sliding fee scale and the mother's ability to pay. No woman will be denied service due to an inability to pay.

While average breastfeeding rates in Pierce County are high at hospital discharge (70%), within 2 weeks these rates drop significantly. Therefore early telephone follow-up is an important component of the Breastfeeding Clinic.

Mothers who are referred by local physicians, hospitals, community health nurses and the WIC program are contacted by phone within two (2) weeks post partum. This phone contact has enabled many discouraged mothers to continue to nurse. Sometimes the solution is very simple and can be handled over the phone without a clinic visit.

What can the Breastfeeding Program do for physicians in Pierce County? In addition to functioning as a referral source for patients, the staff is available for professional consultation and offers inservice programs for hospital and private medical office personnel. Also, a loaner service provides breast pumps to selected mothers who have limited finances.

For more information, call Tacoma-Pierce County Health Department, 591-6409.

—*Gail Brandt*, RD, MPH

A GRAND ADVENTURE

AN INTERVIEW WITH DR. BEN BLACKETT, MEDICAL TEAM MEMBER AND ASSISTANT MEDICAL DIRECTOR FOR THE ULTIMA THULE EXPEDITION

By Mary K. Tipton

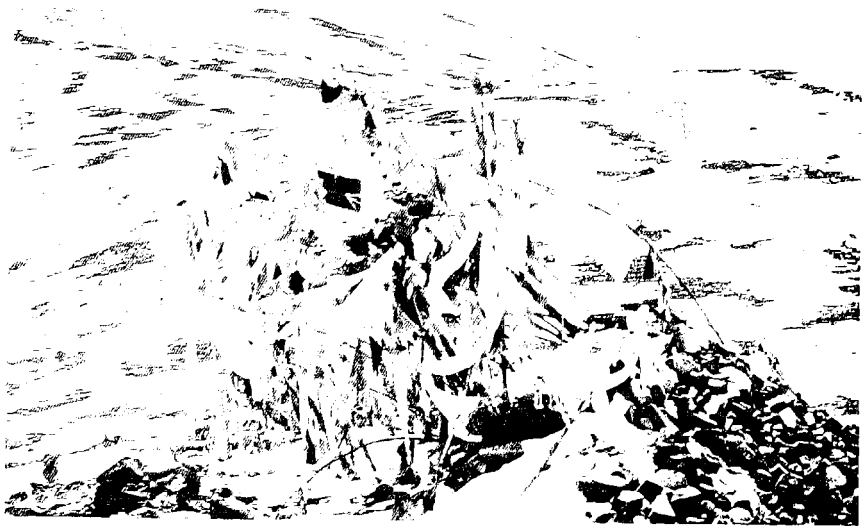
Tacoma Neurosurgeon Dr. Ben Blackett was one of four Doctors to accompany a group of American climbers this year in their attempt to scale Mt. Everest. The following article is based on an interview with Dr. Blackett, June 7, shortly after his return.

the editor

Ultima Thule, meaning far horizons, was the name of the American climbing expedition that recently returned from an attempt to scale 29,028 ft. Mt. Everest. "It was," according to Tacoma neurosurgeon Dr. Ben Blackett and other team members, "a grand adventure."

After four years in the planning, on May 20 lead climbers reached a high point of 28,200 feet, 828 feet short of the summit. Forced to abandon their efforts when oxygen and food supplies ran out, their disappointment was tempered by the success achieved in medical research. According to an Association Press release quoting expedition leader Tom Fitzsimmons, "things were tried over 20,000 feet that had never been done before."

Path leading up the North Col of Mt. Everest from Camp 3.



Prayer flags seen along pass between Lhasa and Everest.

According to Dr. Blackett, who split medical coverage of the expedition with neurosurgeon Dr. Richard Wohns, clinical trials on new soft lens contact lenses were carried out along with studies on the effectiveness of dilantin in preventing high altitude sickness. This was the first time that visual evoked potential studies (measurement of the speed of conduction of light stimulus from the retina to the visual cortex) were done at high altitudes.

Experienced in Himalayan climbing, Dr. Wohns was directly involved in planning the expedition from the outset and covered the first part of the climb beginning in February. Dr. Blackett and Dr. Rick Foutch, Resident in Emergency Room Medicine at Madigan, arrived in April to replace Dr. Wohns. Shortly after their arrival an avalanche on the mountain April 3 claimed the life of British Ar-

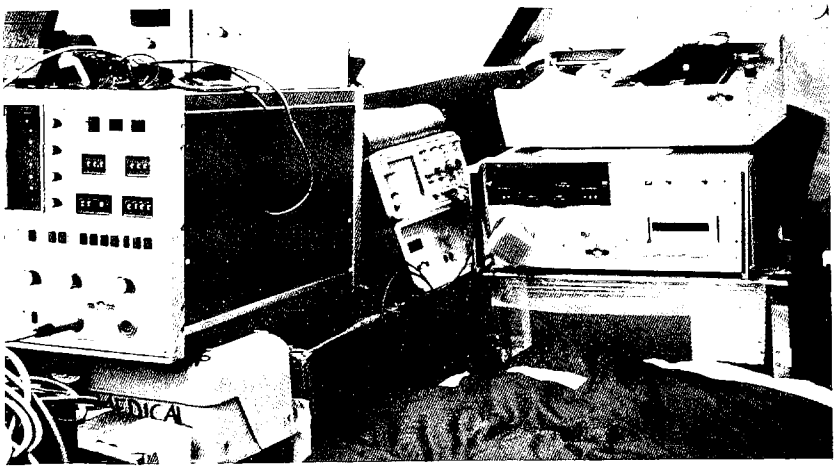
my Serviceman, Lance Cpl. Tony Swierzy. "It was," says Dr. Blackett, "one of the risks of being on the mountain."

Dr. Wohns, Dr. Blackett and Dr. Foutch provided medical care for the four other injured British Army climbers who were with Swierzy at the time of the avalanche.

"There were no surprises," says Dr. Blackett in discussing the expedition. "There was very good team work and everyone was well prepared. We took time to acclimate to the altitude. There were no serious cases of pulmonary or cerebral edema. We did have several retinal hemorrhages. It was very cold on the mountain when the sun went down, so cold our water froze every night. We wore multiple layers of clothing to keep warm."

Yak with cinch and saddle loaded to carry equipment to Camp 3.

Tent site, Base Camp.



Inside medical tent with medical equipment set up: Base Camp.

Tent site, Camp 2, 40 ft. to 80 ft. seracs loom in background.

Climbing to 22,500 feet, Dr. Blackett was later replaced by Dr. Michael Weidman, a Boston opthalmologist. The Ultima Thule expedition approached the climb from China and Tibet via the North Col and the northeast ridge of Everest. This approach was first discovered by the British climber George Leigh-Mallory and A.C. Irvine who died on Everest in 1924. The first successful climb up Everest was from the South Col through Nepal.

On the mountain for three weeks, Dr. Blackett says it took one week to get in and another to get out. Arriving in Peking, a city Dr. Blackett describes as smoke-covered and a bit grim sitting on the edge of the Gobi Desert, he flew from Peking to Chengdu in the southwest of China for the first leg of his trip. From

Summer Palace at Peking.

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MSPC DOCTOR/LAWYER COMMITTEE AND TACOMA-PIERCE COUNTY BAR ASSOCIATION DEVELOP MEMORANDUM OF UNDERSTANDING

Published on the following pages is a copy of the *Memorandum of Understanding* developed by the MSPC Doctor/Lawyer Committee and the Tacoma-Pierce County Bar Association. Appearing in this month's *Bulletin* as a special insert so that it can be removed and kept handy for future use, the Memorandum can serve as a basis for interactions between Tacoma and Pierce County physicians and attorneys.

The *Memorandum*, arrived at following a great deal of discussion in the Committee, was ratified by the Board of Trustees of both professional organizations. The recently signed Addendum brings about minor changes which were requested by the MSPC Board of Trustees. By agreement, any further additions or modifications of this *Memorandum of Understanding* will be considered once a year at the May meeting of the Committee.

The various points made in the *Memorandum of Understanding* were arrived at as a result of the personal experiences of past and present members of the committee, and are also based on the experience gained from attempts at resolution of various commonly occurring problems between members of the Bar and the Medical Society.

I was appointed to the chairmanship of the medical part of the Committee in January 1984. We now have had three meetings. They differ from those occurring in the past, in that both physicians and attorneys meet together. This was done at the request of the Medical Society, and graciously agreed to by members of the Bar. In addition to myself, the physician members of the Committee are: Drs. O'Connell, Foss and Wilson.

So far, my experience has been that the Committee deals almost exclusively with complaints lodged predominantly by the physicians and occasionally by the attorneys, usually revolving around financial dealings. One would think that in the Committee's five years experience the complaints would be mostly repetitious, but it seems that each one brings with it a "new wrinkle."

Out of the attempts at resolving the conflicts we hope to build a body of experience which will, hopefully, help members of both groups avoid difficulties in the future. It is my intention to report to you in the pages of *The Bulletin* the various proceedings of the Committee as they take place.

I would like to express my appreciation to Mr. James Krueger of the firm, *Kane, Vandeberg, Hartinger and Walker*, who chairs the meetings of the Committee with courtesy, efficiency and good humor, and who insures that the Committee's opinions are expressed clearly and with an economy of words.

I have also felt very reassured by the thoughtfulness and consideration shown by all attorney members of the Committee to the problems and difficulties of the physicians. At a time when the members of these two great professions tend to approach one another often with feelings of distrust and resentment, it is gratifying that we can communicate with one another in an atmosphere of confidence and respect.

— *Marcel Malden*, MD. FACP

On behalf of the Doctor/Lawyer Liaison Committee of the Tacoma-Pierce County Bar Association, I want you to know how much we appreciate the constructive working relationship we have enjoyed during the past few years with the Doctor/Lawyer Liaison Committee of the Medical Society.

The *Memorandum of Understanding* entered into between our two professions is a testimony of the desire on the part of both professions to avoid misunderstandings and to amicably resolve disputes which occur from time to time.

More important than the written Memorandum is the positive working relationship currently existing between our two professions. The members of your Committee have time and time again shown a sincere desire to resolve disputes in an absolutely impartial and equitable fashion. This is a testimony to the caliber of individuals who sit on your Committee. Accordingly, we have the utmost respect and admiration for Dr. Malden and the other members of your Committee.

It is our sincere hope that we will continue to enjoy such a constructive and cordial working relationship.

—James A. Krueger, Chairman
Doctor/Lawyer Liaison Committee
Tacoma-Pierce County Bar
Association

MEMORANDUM OF UNDERSTANDING

DOCTOR/LAWYER LIAISON COMMITTEE
TACOMA-PIERCE COUNTY BAR ASSOCIATION
MEDICAL SOCIETY OF PIERCE COUNTY
MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding made and entered into this 11th day of November 1983, by and between the Doctor/Lawyer Liaison Committee of the Tacoma-Pierce County Bar Association ("legal committee") and the Doctor/Lawyer Liaison Committee of the Medical Society of Pierce County ("medical committee").

WITNESSETH:
WHEREAS, the legal committee and the medical committee desire to facilitate communications between their respective professions on matters of mutual concern, and
WHEREAS, in furtherance of the foregoing they entered into a Memorandum of Understanding dated July 12, 1979, and
WHEREAS, the parties now desire to update, supplement and supersede the prior Memorandum of Understanding to clarify some of the matters covered by the prior memorandum and to increase the scope of the understanding between the parties;
NOW, THEREFORE, it is hereby agreed as follows:

1. Availability of Physicians for Court Related and Administrative Proceedings.

1.1 **Physician's Duty to Assist.** All citizens have a legal right to avail themselves of the courts and administrative tribunals and to have representation of attorneys in resolving disputes. In instances where medical information is necessary to the fair resolution of a dispute, the physician should make himself or herself available for conferences with attorneys, depositioners, court appearances, etc., at reasonable times and upon reasonable notice.

1.2 **Physician as Expert Witness.** A physician called as an expert witness in a legal proceeding is an independent witness. While the physician's testimony may be more helpful to one side than to the other, the physician should not become an advocate. The physician should limit his or her participation to stating the truth as he or she sees it.

2. Duties of Attorneys.

2.1 **Notice to Physicians.** Physicians should be given at least 30 days' notice for trial testimony, 15 days' notice for attendance at a deposition, and 7 or more days' notice for office conferences. Every effort should be made to schedule testimony so as to interfere as little as possible with the physician's scheduled time.

2.2 **Compliance With Local Rule.** The attorney should endeavor to comply not only with the letter, but with the spirit of Local Court Rule No. 14, which requires the issuance of a subpoena to a physician in a timely manner. This local rule states as follows:

> *Where an expert witness will, with reasonable probability, be called as a witness at a trial of any case, the party planning to call such witness shall cause a subpoena to be issued and served upon such witness not later than thirty (30) days subsequent to the date the case is assigned for trial, or, in case such witness becomes a necessary witness in the trial of said case subsequent to the date of assignment for trial, then not less than twenty (20) days prior to the trial date. A continuance may be denied should such a witness be unavailable for trial unless a subpoena has been issued and served within the times above specified. For the purpose of this rule, service of a subpoena may be made by mail.*

This rule may be endorsed upon any subpoena issued.

3. Fees.

3.1 **Physician to Charge "Reasonable Fee."** A physician should charge a reasonable fee for the time he or she spends as an expert witness. This fee may be calculated upon a time basis or any other basis which results in a reasonable fee.

3.2 **Charges for "Stand-By" Time.** Charges may be made for time the physician has reserved for a legal proceeding which is cancelled prior to occurring. However, no charge shall be made if the reserved time is cancelled on three business days' notice to the physician. Should the physician receive less than three business days' notice and should the physician be able to utilize all or a portion of that reserved time for chargeable medical services, the "stand-by" charges should be reduced in proportion to the amount of time which was utilized for chargeable medical services.

3.3 **Attorney to Inquire as to Charges.** It is the duty of the attorney to initiate a discussion of fees with the physician.

3.4 **Physician to Disclose Charges.** It is the duty of a physician to furnish to an attorney, upon request, the amount of his or her usual and customary charges.

3.5 **Attorney Not to Pay Medical Bills.** It is improper for a physician to require an attorney to pay the medical bills of a patient before the physician will cooperate with an attorney requesting medical information or testimony.

3.6 **Payment of Physicians' Charges.** Reasonable charges made by a physician for medical reports, conferences, depositions, trial testimony, etc., arranged for by an attorney for his or her client, are payable by the attorney to the physician within 30 days after billing. The physician's charges do not await the final resolution of the case.

3.7 **Payment of Client's Medical Bills.** Attorneys should not advise a client to withhold payment of medical bills pending resolution of a lawsuit. The physician's bills are not contingent upon the outcome of litigation and are payable when billed.

4. Informal Opinions.

Any attorney or physician desiring an informal opinion as to matters of mutual concern between the legal and medical professions may request such an opinion from the chairman of the legal committee or the chairman of the medical committee, or both. Upon receiving a request for an informal opinion the chairman may either render an informal opinion which normally will be oral in nature, or may elect to treat the request as a request for a formal opinion, in which case he or she will comply with the requirements set forth in Section 5 below. An informal opinion represents the opinion of the chairman only and does not necessarily represent the opinion of the entire committee.

5. Formal Opinions.

5.1 **Procedure.** In the event an attorney or a physician desires a formal opinion agreed to by both the legal and medical committees, the following procedures shall be adhered to:

5.1.1 An attorney shall submit an opinion request in writing to the chairman of the legal committee; a physician shall submit an opinion request in writing to the chairman of the medical committee.

5.1.2 The chairman receiving the written request for an opinion shall send a copy of the opinion request, together with any supporting documents, to the chairman of the other committee.

5.1.3 If the requested opinion involves the conduct of another person, that other person will be furnished with a copy of the opinion request and be invited to respond in writing.

5.1.4 The respective committees shall then consider the matter separately and attempt to arrive at an opinion.

5.1.5 Once the respective committees have arrived at their separate opinions the chairman of the two committees shall confer either in person, or by telephone, or in writing to attempt to agree upon the wording of the written opinion. Should the two chairmen be unable to agree upon the wording, a joint meeting of the two committees shall be called for the purpose of determining the exact wording of the opinion.

5.1.6 Once the wording of the opinion has been determined it shall be reduced to writing and signed by each of the chairmen of the two committees.

5.1.7 A copy of the signed opinion shall be sent to the person requesting the opinion, the person, if any, whose conduct is complained about, the president of the Tacoma-Pierce County Bar Association and the president of the Medical Society of Pierce County.

5.2 **No Legal Effect.** A formal opinion shall have no legal effect whatsoever, except that it shall be an expression of the combined views of the legal and medical professions in Pierce County.

6. Arbitration.

6.1 **Procedure.** In the event a formal opinion is requested which involves a complaint by a member of one profession against a member of the other profession the matter may be submitted to binding arbitration so long as **all** participants request arbitration in writing. A request for binding arbitration shall be directed to the chairman of either the legal or the medical committee. Upon receiving a request for binding arbitration the following procedures shall be followed:

6.1.1 All attorneys and physicians involved in the disputed matter shall be contacted and asked to consent to the binding arbitration in writing. If less than all of the affected attorneys or physicians fail to consent to binding arbitration the matter shall be handled as a request for a formal opinion as provided for in the preceding Section 5.

6.1.2 If the consent of all affected attorneys and physicians is received in writing then the chairman of the legal committee and the chairman of the medical committee shall constitute two of the three arbitrators. The third arbitrator, who shall be neither an attorney nor a physician, shall be jointly selected by the chairman of the legal committee and the chairman of the medical committee.

6.1.3 The three arbitrators shall then proceed to arbitrate the dispute in accordance with the provisions of Chapter 7.04 of the Revised Code of Washington, not inconsistent with the provisions of this Section 6.

6.2 **Effect of Arbitration Award.** The award of the arbitrators shall be final, conclusive and binding upon all parties thereto and may be confirmed by any court having jurisdiction thereof, as provided in Section 7.04.150 of the Revised Code of Washington.

7. Ratification.

This Memorandum of Understanding shall have no force or effect until it has been ratified by the governing bodies of both the Tacoma-Pierce County Bar Association and of the Medical Society of Pierce County.

IN WITNESS WHEREOF, the parties have signed this Memorandum of Understanding on the day and year first above written.

ROBERT A. O'CONNELL, MD,
Chairman, Doctor/Lawyer
Liaison Committee, Medical
Society of Pierce County

JAMES A. KRUEGER, Chairman,
Doctor/Lawyer Liaison Committee,
Tacoma-Pierce County Bar
Association

A Grand Adventure,
continued from page 13

Chengdu he flew to Lhasa, 12,000 feet altitude, home of the original kings of Tibet and the Dalai Lama, where he and other team members stayed for three days to acclimate to the altitude.

According to Dr. Blackett, the 70 mile ride from the airport to Lhasa took four to five hours riding over very rough roads. "I couldn't decide if they were demolishing or making the road," he says.

In describing his flight from Chengdu to Lhasa, Dr. Blackett says the plane flew just north of the eastern Himalayas. "You could tell," he says, "that the mountain range is still young and growing from the knife-like ridges visible from the plane."

"Everest," he claims, "is not the most difficult to climb. There are others in the range more difficult," he says, "and many which would be giants elsewhere in the world sitting unnamed and unclimbed."

Wildlife in the area of Tibet included wild sheep, goats and birds, including the large Gorak.

Base Camp, set up at about 17,000 feet, was a three day jeep ride from Lhasa over very rocky and tortuous passes extending up as high as 17,000 feet. It was a ride Dr. Blackett says he will never forget. "Most of the time I had my hand on the roof of the jeep to keep from bouncing and hitting my head."

Snow level on the mountains when Dr. Blackett and Dr. Foutch arrived to replace Dr. Wohns was about 19,000 feet. The terrain was rocky and desolate with "tremendous winds. We wore surgical masks, " says Dr. Blackett, "to keep the dust out. Sand dunes along the Yarlung River were as high as 800 feet."

Medical equipment and other supplies brought up by jeep to Base Camp were carried further up the mountain by yaks.

continued on page 19

HEALTH REPORT

TIME OF EXAMINATION: For athletics, during the 12-month period prior to first participation in interscholastic athletics in middle school or junior high school, and prior to participation in high school. Clearance for continued participation is to be provided on this form prior to each subsequent year of interscholastic athletics. A yearly clearance from the examiner is needed for continued participation.

CHOICE OF EXAMINER: It is recommended that each child have a personal physician knowledgeable regarding each aspect of his/her health. Examination may be performed by a licensed physician (M.D. or D.O.), a licensed physician's assistant, or a certificated pediatric or family nurse practitioner working under the direction of a physician whose name is to be stated.

THIS SECTION IS TO BE COMPLETED BY THE PARENT OR GUARDIAN BEFORE EXAMINATION BY THE PHYSICIAN. PLEASE PRINT.

Last Name First Middle Birthdate: Month/Day/Year Sex: F or M Name of School, Camp or Organization

Name of Parent of Guardian Address Zip Home Phone Work Phone

Usual Physician or Source of Health Care Phone Dentist Phone

CIRCLE PURPOSE(S) OF REPORT: *SCHOOL:* Preschool, Kindergarten, Elementary School, Junior High, High School. To enter grade _____ September 19_____.
INTERSCHOLASTIC ATHLETICS: baseball, basketball, cross country, football, gymnastics, soccer, swimming, tennis, track, volleyball, wrestling.
OTHER: day care, developmental center, child study, park board recreation, boys club, camp, lifesaving, other (specify) _____

IS THERE ANY ILLNESS OR HANDICAP, or other situation which might affect performance? (Please explain)

CHILD HAS OR HAD THE FOLLOWING: Circle the appropriate item(s), and explain on the right. Name other doctors important in child's care.

SKIN: acne, eczema
VISION: glasses, contacts
HEARING: aids
NOSE: bleeding
MOUTH: dental decay, orthodontia
LUNGS: asthma, bronchitis
HEART: congenital, rheumatic
GASTROINTESTINAL: ulcer, colitis, hepatitis
GENITOURINARY: kidney or bladder infection
Menstruating, if female: Yes ( ) No( )
ORTHOPEDIC: fracture or sprain, scoliosis, congenital hip
NEUROLOGICAL: convulsions, meningitis, cerebral palsy
METABOLIC: diabetes
BLOOD: anemia, sickle cell disease
ALLERGIES: food, insect, pollen, contact, drugs, other, (specify) _____
HOSPITALIZATION(S): (Year & Reason) _____
OPERATION(S): (Year & Reason) _____
HANDICAP: physical, mental, behavioral, social, learning, vision, hearing, speech, hyperkinesis

Has child had: rubeola ( ), rubella ( ), mumps ( ), chicken pox ( ), whooping cough ( )
If child under 3 years give birthweight _____ Describe unusual factors regarding birth or health immediately after birth _____

IMMUNIZATIONS	None	Doses Received 1	2	3	4	5 or more	Month/Year of Last Immunization	Immunizations
Diphtheria, Tetanus, Pertussis Any combination of DTP/DT/Td								DTP, DT, Td (circle dose given)
Oral Polio Vaccine (OPV)								OPV
Rubeola (7 day or hard measles)				Immunization report need not be completed if a separate immunization certificate is being submitted at the same time.				Rubeola
Rubella (3 day, mild or German measles)								Rubella
Mumps								Mumps

I certify that to the best of my knowledge the information given above is accurate and the immunizations checked have been received. Date Signature: Parent or Guardian

THIS SECTION IS THE RESPONSIBILITY OF THE PHYSICIAN. PARENT(S) SHOULD BE PRESENT FOR EXAMINATION.

Date of examination Height Weight Blood pressure Hearing: Right Left Hematocrit Sickle Cell Hemoglobin Urinalysis

Vision: Right 20/ Left 20/ Vision corrected: glasses, contacts (circle which) Right 20/ Left 20/ Color Vision Tuberculosis skin test: Date Type Result

CIRCLE ABNORMAL AREAS. DISCUSS AT RIGHT

Appearance	Scalp	Throat	Neurological
Development	Head	Chest	Dental
Nutrition	Eyes	Lungs	Genitalia
Acne	Ears	Heart	Extremities
Rashes	Nose	Abdomen	Back (Shows no evidence of Kyphosis or Scoliosis)

An additional narrative report is attached or will be forwarded. Yes ( ) No ( )

INTERVAL NOTE: Identify any occurences since examination which could effect participation in school, athletics, or other activites.

REFERRAL(S) (Circle) Eye, Ear, Dental, Orthopedic, Other (describe) _____ Parents need help to obtain Yes ( ) No ( )
Please name other doctors involved in care of child:

ASSESSMENTS THAT MAY BE NEEDED IN SCHOOL OR OTHER FACILITY: Hearing, Speech, Psychology, Occupational therapy, Physical therapy, Guidance, Learning. If you believe child should be considered for special education, please describe need above.

MEDICATIONS REQUIRED TO BE GIVEN IN SCHOOL OR OTHER FACILITY. Diagnosis _____

Name of medication Form Dose Time Duration of prescription Possible effects

RECOMMENDED PHYSICAL ACTIVITY:
- Full day care, preschool, school, physical education, sports or camp activity.
- Swimming
- Modified or restricted activity (describe).
- Interscholastic athletics. If wrestling, not to go below what weight? _____ lb.

A physician's written release is required to resume participation following all illness and/or injury serious enough to require medical care. Give details above.

Date signed Next recommended date of examination Physician's Name (Please print) Signature and Title

Prepared by the Medical Society of Pierce County in cooperation with Tacoma and Pierce County preschools and schools, Tacoma-Pierce County Health Department, Department of Social and Health Services, child care, youth and camping organizations.

TPS - 25 - 7/79 Revised 9/81

For Medication Given at School

PHYSICIAN ORDER FORM APPROVED

Recent changes in state law permit the giving of oral medication to students during school hours provided proper authorization from physicians and parents is obtained. Use of a standardized county-wide form has been suggested (see The Bulletin, "Public Health/School Health Report," November, 1982).

The Public Health/School Health Committee has approved the following form for physician use. The form is published in this issue for the convenience of physicians. Please have your office staff reproduce the form as needed. — The Editor

Medical Society of Pierce County
Physician's Orders for Medication at School

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the medication will be dispensed by the principal or his/her designee in the absence of the school nurse.

Only prescription oral medication will be administered. The principal will designate the person responsible to dispense medication on an individual basis.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Is it necessary to dispense this medication during school hours? _____ Yes _____ No

If yes, please give diagnosis or reason: _____

_____

Name of patient: _____

Drug and dosage form: _____

Dose and mode of administration: _____

Hour(s) to be given: _____

Duration without subsequent order: _____

Side effects of drug (if any) to be expected: _____

Date: _____ Physician's signature: _____

Parent's Permission

I request that the principal or a staff member designated by him/her be permitted to dispense to my child, (name of child)

_____ the medication prescribed by (name of physician)

_____ for a period from _____ to _____.

The medication is to be furnished by me in the original container labeled by the pharmacy or physician with the name of the medicine, the amount to be taken, and the time of day to be taken. The physician's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions. This authorization is good for the current school year only. In case of necessity the school district may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed. I am the parent or the legal guardian of the child named.

Date: _____ Signature of parent or guardian: _____

Student's home address: _____ School: _____

MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

SCOTT L. HAVSY, DO, *Sports Medicine.* Born on 5/4/53. Medical school, University of Miami, 1978; internship, Brooke AMC San Antonio, TX, 7/78-10/78, Madigan AMC, Tacoma, WA, 7/79-6/80; Washington State License, 1980. Dr. Havsy is currently practicing at 1410 Meridian South, Puyallup, WA.

SAMUEL J. INSALACO, MD, *Pathology.* Born in New York, 11/29/48; State University of New York, College of Medicine, 1974; internship, Tripler Army Medical Center, Honolulu, HA., 7/74-6/75; residency, Walter Reed Army Medical Center, Washington, D.C., 7/76-6/79; Washington State License, 1980. Dr. Insalaco is at present the staff pathologist at Tacoma General.

MICHAEL P. YOUNG, MD, *Family Practice.* Born in Granite City, IL, 5/8/50; St. Louis Univ. School of Medicine, St. Louis, MO, 1977; internship, 6/77-6/78 and residency, 6/78-6/80, both received at Dwight D. Eisenhower Army Medical Center, Fort Gordon, GA, Family Practice; Washington State License, 1980. Dr. Young is currently practicing at 9915 112th Street East, Puyallup.

DAVID R. MUNOZ, MD, MPH, *Geriatrics/Internal Medicine & Emergency/Trauma.* Born in Los Angeles, CA, 3/31/52; Harvard Medical School, 1978; internship, University of Washington, 6/78-6/79; residency, University of Washington, Internal Medicine, 7/79-7/80; MPH Preventive Medicine, graduate of Public Health and Preventive Medicine; fellowships: Clinical Scholars Program, Dept. of Med. & Veterans Admin., Seattle, WA, 7/80-7/82; Geriatrics & Gerontology, Univ. of WA, 7/82-7/83; Rheumatology, Univ. of WA, 7/82-7/83. Washington State License, 1984. Dr. Munoz is currently practicing at 408 South "K" Street.

A Grand Adventure,
continued from page 15

The Nicolet Evoke Potential Monitor, according to Dr. Blackett, "survived" the jeep trip but "succumbed temporarily to the yak trip." They were, however, able to salvage it. Using 60 cycle, 110 volt generators, the medical team was able to carry out much of the research they had set out to do. As a pre-agreed condition of the climb, however, according to Dr. Blackett, there were "no invasive procedures conducted."

In describing the climb, Dr. Blackett says he remembers times of great elation and excitement and other times of extreme boredom. "Getting our feet warm at the time was the main concern we all shared," he says.

Seven Camps were set up for the climb. Camp 2 was set up in an area where there were numerous seracs (20 to 80 feet high walls of ice). 15 miles from Base Camp, Camp 3, at 21,000 feet, was set up just below the North Col. While yaks carried supplies and medical equipment from Base Camp to Camp 3, from Camp 3 all equipment and supplies had to be carried by team members.

"Meals at Base Camp," says Dr. Blackett, "were more like home cooked meals." Canned food was used at Base Camp while freeze dried food was consumed by team members above Base Camp. Water was boiled or treated with iodine and often drunk as tea.

Above 17,000 feet, according to Dr. Blackett, fluid loss is significant. "It was important," he says, "that we took in extra fluids to keep hydrated.

"We needed a high calorie intake also, but we were fighting at the same time the loss of appetite that occurs with the high altitude. I estimated that I had lost about 20 pounds when I came down from Camp 3."

With prolonged exposure, Dr. Blackett says, the body deteriorates, metabolizing the muscle mass. The process reverses itself when descending to altitudes below 16,000 feet.

Glad to be back in Tacoma, and giving credit to Dr. Wohns for the opportunity to climb Everest, Dr. Blackett says he and the other members of the expedition went where few Westerners ever get the chance to go. "It was, indeed," he says, "a grand adventure." ■

Note: We would like to extend our thanks to Dr. Blackett for sharing his photographs for publication in this months issue of The Bulletin.

CLASSIFIED

Gig Harbor Practice Opportunity—Fully equipped medical office at Harbor Park Professional Center. Available for immediate occupancy. 1,080 square feet of space with top quality equipment. Ideal for primary-care or share with other sub-specialist. Call (206) 851-5578 for details.

For Sale by owner—Downtown deluxe condominium; top floor, vaulted ceiling, 2-bedrooms, unobstructed bay view; minutes from TG and St. Joseph. $129,000; 272-1788.

Family Physicians Needed—for suburban community clinics in South King County. Full and part-time positions. Provision of direct patient care. Regular hours, Monday thru Friday. No call at present. Washington State medical licensure required. Board certification in family practice desirable. Contact: Molly Lanegraff, Clinic Coordinator, Valley Community Clinic, 1025 S. 3rd, Renton, WA 98055. (206) 226-7039

Lakewood—1,500 sq. ft. Medical Dental Bldg. Good location for dental specialists. High visibility. Call Dr. Kenneth P. Ring 584-6200.

German Physician's—19-year-old daughter wants to improve English skills as aupair girl with American family, beginning September. Call J.H. Duenhoelter, MD, 848-1574.

Lakewood General Practice Opportunity—Lease the space; start practice with many referrals. Call: 473-7303.

Northeast Tacoma Professional Center—Great Location above Brown's Point. New professional office space. Two blocks from Jr. High. Energy efficient. Full basement for mechanical and storage. Interiors to suit. Super competitive leasing terms. This great community needs a medical office. Dennis/Jean (206) 272-2713.

Vacation Rental—Friday Harbor, San Juan Island. Waterfront condo, 3-bedroom, 2-bath, completely furnished, moorage, 23 ft. cruiser. Seasonal rates. Unit E-214. Call 1-378-5858.

View Home: Gig Harbor—Now $120,000 by owner. I've slashed $16,000 off the price on this 2,800 sq. ft., 3 bedroom home with many amenities. Must sell by summer. Call George: 1-851-5248.

EMERGENCY MEDICAL SERVICES (EMS) SEEKING PHYSICIAN

The Emergency Medical Services Division of the Tacoma/Pierce County Health Department is seeking a physician to serve as medical advisor to the EMS Division and as Pierce County EMS Medical Program Director. Applicants may anticipate working approximately 32 hours a month in a paid consultant capacity providing medical direction and guidance to the EMS community. Resumes must be submitted to the EMS Division by August 15, 1984. Interviews will be held.

Position Prerequisites:

- *Minimum three years emergency medical experience.*
- *Active in the Pierce County EMS system.*
- *Administrative experience (preferred)*
- *American College of Emergency Physicians member (preferred)*
- *American Board of Emergency Medicine Certified (preferred)*
- *Resident of Pierce County (preferred)*

Division of Emergency Medical Services, Tacoma-Pierce County Health Department, 420 South Fawcett, Tacoma, Washington 98402, (206) 591-5747.

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Among those who experience hearing impairment in both ears, more than 50 percent are over 65 years of age. It is not surprising if elderly hearing-impaired persons are among your patients.

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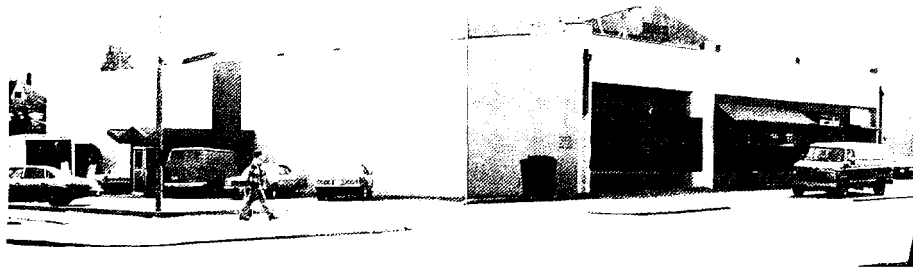
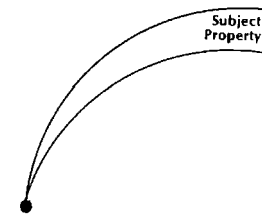


PROPERTY OFFER FROM PACIFIC BUSINESS INVESTMENTS

Approximately 10,000 sq. ft., plus full basement. Easy to remodel into medical facilities.

$40,000 tax credit.

Concrete structure. Roof is heavy beam construction with adequate pitch to assure a long life. Near downtown hospitals with ample room for 20 or more parking spaces.



Property is offered as one parcel for $250,000.00.

Broker inquiries invited. Full co-brokerage cooperation.

Contact Ed Danz or Vi Barner
535-3050

PACIFIC BUSINESS INVESTMENTS
Phone (206) 535-3050
Residence 272-5981

Who comes first: physician or patient?

At Manor Care of Meadow Park Convalescent & Rehabilitation Center, we're happy to say—neither. Our concern is providing quality care for each of our patients. Your concern is the same for your patients. So our efforts coordinate in every way we know how. Let's look at some examples.

Our Admission Coordinator helps your patients and their families through the admission procedure. We work with you and your office staff throughout the patient's stay and help ensure an orderly transfer at discharge time.

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Our food service manager and Registered Dietician consult to provide special diets.

Our unit-dose medication system assures fresh medications and accurate dosages.

Our extensive in-service education progams keep our staff up-to-date on latest concepts and renew basic geriatric practices.

It's not that no one comes first at Manor Care. It's that everyone does. Why not call or visit? Then you'll be sure.

MANOR CARE

Convalescent & Rehabilitation Center

5601 South Orchard St.
Tacoma, WA 98409
(206) 474-8421

A Member of The Manor HealthCare Community.

A WORD TO THE WHYS

WHY AMA?

The AMA actively works to represent your interests by fostering legislation that is beneficial both to the medical profession and the public. Each year the AMA makes thousands of contacts with members of congress and their staffs and frequently translates Association policies into model or draft legislation for governmental action. Active representation of organized medicine: it's one more good reason why you should be part of the AMA.

WHY AMA? Today you can have instant access to a broad range of up-to-the-minute clinical information and protocols for use in patient care through the Medical Information Network. This nationwide, computerized system was developed by the AMA, with General Telephone and Electronics (GTE), to provide you with the most advanced, current scientific information. It's one more reason why you should be a part of the AMA.

WHY AMA? Residents and medical students now have a strong voice in organized medicine. Through the Resident Physician Section and the Medical Student Section, these two groups participate in the policy making process of the AMA and communicate their concerns. Developing future leadership in organized medicine: it's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

MEDICAL SOCIETY OF PIERCE COUNTY
705 South 9th, Suite 203
Tacoma, Washington 98405
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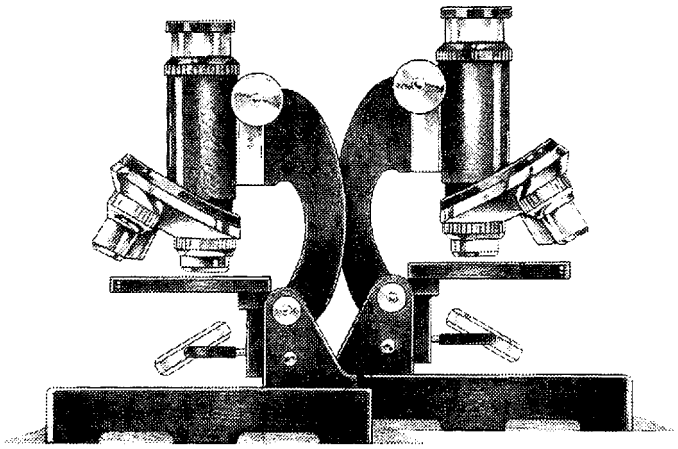
The Bulletin
MEDICAL SOCIETY OF PIERCE COUNTY

September 1984

BLUE CROSS COVERAGE IS CHANGING IN TWO IMPORTANT WAYS.



In response to employer demand for cost containment programs, Blue Cross of Washington and Alaska is now implementing the Second Surgical Opinion Program (SSOP) and the Outpatient Surgery Program (OSP).

Mandatory Second Opinions. With SSOP, Blue Cross requires its subcribers seek a second surgical opinion after surgery is recommended by a physician, though the second opinion need not be confirming.

SSOP applies to elective, non-emergency procedures only. The Plan pays 100% of UCR for all required second opinions.

Outpatient Surgery. For groups that have the OSP, Blue Cross requries that certain elective procedures be performed on an outpatient basis or be precertified for inpatient.

Outpatient Settings. Outpatient surgery may be performed in a doctor's office, free-standing surgical center, or hospital outpatient location.

Benefit Requirement. SSOP and OSP requirements must be followed or the subscriber will be financially responsible for the primary surgeon's fee.

For a brochure and complete list of SSOP/OSP forms and procedures, contact Blue Cross Customer Service at P.O. Box 327, Seattle, Washington 98111.

Blue Cross
of Washington and Alaska

The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Cover Photo *Courtesy, Tacoma Public Library*
Health Center for the "Woman's Benefit Association,"
953 Broadway, Tacoma, WA. 1930.
Figure in the photograph is
Frances B. Gillespie.

CHANGING YOUR ADDRESS? HAVE A NEW ADDRESS?

Please fill out this **change of address** card and return to:

Medical Society of Pierce County
705 S. 9th
Tacoma, WA 98405

NAME _____

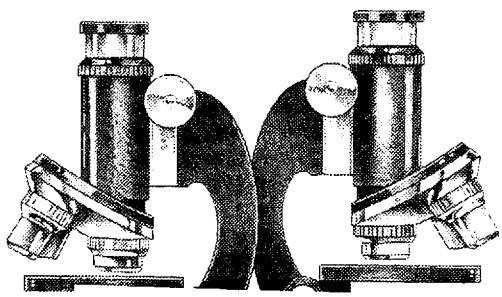
OLD ADDRESS _____

_____ PHONE _____

NEW ADDRESS _____

_____ PHONE _____

BLUE CROSS COVERAGE IS CHANGING IN TWO IMPORTANT WAYS.



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Outpatient Surgery. For groups

Place Stamp Here

Medical Society of Pierce County
705 S. 9th
Tacoma, WA 98405

The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Cover Photo: *Courtesy, Tacoma Public Library.*
Health Center for the "Woman's Benefit Association,"
953 Broadway, Tacoma, WA. 1936.
Figure in the photograph is
Frances B. Gillespie,
Health Supervisor for the Health Center.

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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President's Page

SOME SOBERING THOUGHTS AS SUMMER ENDS

Like most of us, during my lifetime I have always attempted to look at the bright side of things. However, sometimes as I review the political medical climate, it is difficult to maintain that positive attitude. In this article, I want to address some of the political changes affecting the daily lives of physicians. My comments, admittedly, are superficial introductions to the problems, but I hope they arouse your curiosity sufficiently to look more deeply at the issues which interest you.

• **Medicare Changes:** The Deficit Reduction Act of 1984 (House Resolution 4170) freezes Medicare reimbursements for the period July 1, 1984-September 30, 1985. It also outlines the necessity for decisions to determine if physicians will accept all assignments under Medicare and become "participating physicians"—or not accept certain assignments and become so-called "non-participating physicians."

Although this sounds innocent enough on the surface, a closer look at this provision reveals that it is close to forcing you to be a participating physician. Those of us who do not elect to do so will have the option of charging our own fees on a claim-by-claim basis. However, if such "non-participating physicians" increase their fees to Medicare beneficiaries during this 15-month freeze, they may be subject to civil monetary penalties up to $2,000 per violation, and suspension from the Medicare Program for up to five years. Compliance with this requirement will be determined by individual fee profiles, using as the base measuring period April 1-June 30, 1984.

There are many other troublesome parts of this Medicare bill, dealing with outpatient diagnostic laboratory studies, pacemaker reimbursement, hospital room emergency services, PSRO funding, PSRO contract extension and hospital reimbursement, to name a few.

If you are interested in further study of this bill, I am sure you may request of the Washington State Medical Society a summary of a leadership memo dated July 23, 1984, and written by Richard B. Amber, MD, president of the WSMA.

• **Business Meeting of WSMA: Hospital/Medical Staff Section:** The first business meeting of the new WSMA Hospital/Medical Staff Section will be held Wednesday evening, Sept. 12, 1984, at the Seattle Westin Hotel in conjunction with the Washington State Medical Society convention.

We are formally urged to support local medical staff representation at this meeting, which will stress the importance of the new section and its intent to stimulate increasing communication among physicians, members of hospital medical staffs and the WSMA, as well as provide an avenue for medical staff members to have direct access to the WSMA policy-making House of Delegates.

Please note that any WSMA member may submit a resolution for consideration by this committee. While August 1 is the deadline for submitting resolutions for inclusion in the Hospital/Medical Staff Section meeting packet, submission of resolutions is possible through September 1.

• **Contracting:** The Medical Society of Pierce County will introduce to the House of Delegates a resolution calling for establishment of a committee to study various contractual agreements which may be entered into by physicians and provide specific advice to those physicians. Among issues which might be addressed: What are the options in the contract which a physician may want to accept or deny? What are their implications for future contracts? What are options if a physician finds a contract is unacceptable? These are only a few of the questions to which we must know answers before entering into any specific contract.

• **Earnings Gap:** The July 9, 1984, edition of *Medical Economics* contains a revealing article on this subject written by Phillip R. Alper, MD, an internist from Burlingame, CA. I encourage not only the big income, high-tech specialists to read it, but also the medical generalists. Dr. Alper summarizes some of the factors which imperil the survival of a fee-for-service practice. He focuses on the cognitive, as well as procedural, fees and their effect not only on physicians, but on hospitals and other health care agencies.

• **Malpractice Insurance:** I purposely saved this issue for last. I have in front of me a statement by a Florida physician: "A family physician pursuing a usual practice—no hospital or surgery privileges—pays about $5,000 per year in malpractice insurance. If that physician delivers even one baby, the rate goes up to $55,000 annually.

He reported further that, by next year, that rate will have increased to $70,000 per year, which effectively takes obstetrics out of the hands of family practitioners. Whether you agree or disagree with the last statement, no doubt, depends on which side of the tracks you're standing at present.

Upon a review of this column, my first impulse is to wrap it up quickly, go home and have a drink. However, I must remember to stay out of the hands of the Impaired Physicians Committee!

—JPD

LOCAL NEWSBRIEFS

95TH WSMA ANNUAL MEETING WILL FOCUS ON CRITICAL MEDICAL ISSUES

September 12-16, Seattle

From the opening ceremonies to the closing gavel, the WSMA annual meeting will sharply focus on the issues most important to the practice of medicine in the mid 1980s.

All WSMA members are invited. The meeting will be held in Seattle at the Westin Hotel, September 12 through September 16.

Physicians will have an opportunity to learn, listen, debate and renew friendships and acquaintances throughout the state at this most important meeting of the year.

GENERAL MEMBERSHIP MEETING, SEPTEMBER 11:

PEER REVIEW

Nancy B. Cannon, Manager, Employee Benefits Cost Control, Boeing Company; Andrea Castell, Executive Director, Peer Review Organization of Washington and Don Doubles, Benefits Consultant, William Mercer, Inc., will be part of the September 11 General Membership meeting to discuss how business looks at medicine, the concerns of the health care purchaser and the health care package.

Held in the Sheraton Hotel at 6:30 P.M., the September 11, General Membership Meeting is your opportunity to hear what's happening in this area of medicine, a major concern to Society members.

In addition to the presentations of Castell, Cannon and Doubles, four members will be elected to the Nominating Committee. The Committee will meet in October to select a slate of at least two candidates for each vacancy to be filled in elective offices.

PRESIDENT REAGAN'S CANCER PANEL TO MEET AT THE FRED HUTCHINSON CANCER RESEARCH CENTER, OCT. 1

President Reagan's Cancer Panel will meet October 1, 1984, at the Fred Hutchinson Cancer Research Center in Seattle to examine the role of Cancer Centers in the National Cancer Programs. The Panel will address the issue of how to achieve a 50 percent reduction rate in deaths due to cancer by the year 2000, a goal set for the nation by the National Cancer Institute.

DR. DONALD W. SHREWSBURY AUTHORS CHAPTER IN NEW TEXTBOOK ON OTOLOGY

Pierce County Medical Society member Dr. Donald W. Shrewsbury recently authored a chapter for the new textbook *The Diagnosis and Management of Hearing Loss.* Edited by William L. Meyerhoff, MD, Ph.D., Dallas, Texas, the published textbook is on otology. Subject of the chapter Dr. Shrewsbury authored is tinnitus.

More from Sound to Narrows Fun Run

Three more names have been added to the list of those running in the 12th Annual Sound to Narrows Fun Run:

Bill Rinker *Mary Rinker* *Robert Alston*

ARE YOU ON OUR DOCTORS' REFERRAL LIST?

Did you have your name put on the patient referral list when the last questionnaire was sent out April 10? If you are not sure, why not call the Medical Society office and make certain your name is on the list. We have over 300 calls a month from persons seeking physicians.

Local Newsbriefs continued on page 6

PRESIDENT REAGAN SIGNS "DEFICIT REDUCTION ACT OF 1984"

The "Deficit Reduction Act of 1984 (H.R. 4170) passed by Congress June 27, and signed into law by President Reagan, July 18, contains over 300 provisions, including over 60 provisions, specifically related to the Medicare and Medicaid programs.

While Congress rejected a proposal to mandate assignment for all Medicare claims, H.R. 4170, now Public Law 369, does include a provision directly related to physician reimbursement under Medicare. The provision reads as follows:

The customary and prevailing charge levels recognized by Medicare will be frozen until October 1, 1985 at the levels recognized on June 30, 1984. During this 15-month freeze, physicians will receive a series of "incentives" to "participate" by accepting assignment for all claims related to Medicare patients. Also, any increases in the customary charges made by these "participating physicians" will be taken into account in updating their customary charge profile at the end of the freeze. Physicians who accept assignment on a case-by-case basis will be subject to civil monetary penalties (of up to $2,000 per occurrence) and exclusion to the Medicare program (for a maximum of 5 years) for knowingly and willfully billing patients enrolled under Part B for actual charges in excess of their historical charge base for the months of April, May and June 1984.

For a complete description of this proposal and other health care provisions contained in H.R. 4170, please call the Medical Society Office, 572-3666, and a copy will be sent.■

Medical Society of Pierce County

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

"THE HEALTHCARE MARKETPLACE"

SEPTEMBER 11 GENERAL MEMBERSHIP MEETING NOTICE

"Will It Be Inpatient Or Outpatient?"
"Who Makes The Decision For 2nd Opinion On Surgery?"
"What Is Happening In The Healthcare Community?"
"What Should The Doctor Look For?"

A Look At The New Benefit Plans Being Offered. . . .
An Opportunity For The Physician To Ask Questions And Get The Answers
From People Who Know What Is Happening In The Healthcare Marketplace!!!

HEAR: Nancy B. Cannon, Manager, Employee Benefits Cost Control, The Boeing Company
Andrea Castell, Executive Director, Professional Review Organization of Washington
Don Doubles, Benefits Consultant, William Mercer, Inc.

DATE: Tuesday, September 11, 1984

TIME: 6:30 pm—social hour
7:15 pm—dinner
8:00 pm—program

PLACE: Sheraton Tacoma Hotel
So. 13th & Broadway Plaza

COST: Dinner, $16.50 per person.
(price includes tax and gratuity)

Register today. Space will be limited. Mail this form, with a check for the appropriate amount, to the Medical Society in the business reply envelope provided. Or, call the office, 572-3667, to confirm your attendance. Make check payable to Medical Society of Pierce County.

REGISTRATION

Yes, I have set aside the evening of September 11 to hear "The Healthcare Marketplace."

☐ Reserve _____ dinner(s) for me at $16.50 each (price includes tax and gratuity).
Enclosed is my check for $_____.

Dr. _____ Telephone _____

RETURN TO MEDICAL SOCIETY OF PIERCE COUNTY NO LATER THAN FRIDAY, SEPTEMBER 7

A WORD TO THE WHYS

WHY AMA?

The AMA actively works to represent your interests by fostering legislation that is beneficial both to the medical profession and the public. Each year the AMA makes thousands of contacts with members of congress and their staffs and frequently translates Association policies into model or draft legislation for governmental action. Active representation of organized medicine: it's one more good reason why you should be part of the AMA.

WHY AMA? Today you can have instant access to a broad range of up-to-the-minute clinical information and protocols for use in patient care through the Medical Information Network. This nationwide, computerized system was developed by the AMA, with General Telephone and Electronics (GTE), to provide you with the most advanced, current scientific information. It's one more reason why you should be a part of the AMA.

WHY AMA? Residents and medical students now have a strong voice in organized medicine. Through the Resident Physician Section and the Medical Student Section, these two groups participate in the policy making process of the AMA and communicate their concerns. Developing future leadership in organized medicine: it's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

Lifeline® Emergency Response System to be Installed for Elderly and Handicapped

"Lifeline®," an emergency response system for the elderly and handicapped, is soon to be installed in Pierce County. The system, set up to give the elderly and handicapped an emergency access currently unavailable, will be installed and monitored through St. Joseph hospital. In addition, the emergency response system will cover not only Pierce County, but also the Peninsula Area, Kitsap County and South King County.

While the system will be monitored through St. Joseph's facilities, the "Lifeline® Information Card" given to each user will include hospital preference. This will enable the user to be taken to the hospital of their choice if the emergency requires hospitilization.

The Lifeline® system includes electronic equipment installed in the home with a portable help button and home unit linked to the telephone to summon emergency assistance. Trained personnel will provide 24-hour coverage to respond in the event of an emergency.

Hospital volunteers and community service organizations will be used to install the home units and provide training for Lifeline® users on equipment operations. The units will be rented to patients for a nominal monthly fee—$10 to $15—with special funding assistance for those who need the service but cannot afford it.

Designed by Andrew S. Dibner, a Boston University Specialist in rehabilitation and gerontology, the Lifeline® system was studied and tested under a $640,000 U.S. Department of Health, Education and Welfare research grant.

During the last four years over 500 hospitals and agencies across the country have established Lifeline® programs.

MSPC PROFESSIONAL RELATIONS COMMITTEE

Your colleagues want to help

Medical Problems
Drugs
Alcohol
Retirement
Emotional Problems

Members of the Professional Relations Committee for physicians

William A. McPhee 474-0751
Patrick Donley 272-2234
Ronald C. Johnson 841-4241
Jack P. Liewer 588-1759
Robert A. O'Connell 627-2330
Dennis F. Waldron 272-5127

DRG's HAVE YOU PUZZLED? HOW ABOUT PPO's, IPA's, CONTRACTING, HMO's

IS YOUR RECEPTIONIST ANSWERING THE PHONE CORRECTLY? IS SHE TURNING YOUR PATIENTS AWAY?

There are resources available for you at your Medical Society office to help you answer these questions. We have packets of information, brochures, pamphlets and cassettes. Most of these items are free or available on a loan basis. You will find listed on the following page a list of pamphlets, brochures, booklets and cassettes currently available at the Medical Society Office. Call 572-3667, and we will mail the item(s) you request to you.

RESOURCES AVAILABLE AT YOUR SOCIETY'S OFFICE

DRG Pamphlet: "What Your Patient Should Know about DRG's and the Prospective Payment System"

This 24-page booklet is designed to assist physicians in answering patient inquiries. It also may be read and understood easily by the patients themselves. The booklet describes how and why congress developed prospective pricing and provides an overview of how the system is intended to work in hospitals.

DRG's and the Prospective Payment System: A Guide for Physicians

This 70-page booklet has been prepared to inform physicians of the basic requirements of the prospective payment legislation, provide some of the specifics of implemented regulations and advise on potential implications for physicians and hospitals.

A Physician's Guide to Preferred Provider Organizations

This publication was prepared in response to a growing number of requests for information and assistance. It is intended to serve as a resource and guide to physicians who want to explore the PPO concept either from a participation or a planning and implementation standpoint.

Current Opinions of the Judicial Council of the American Medical Association, 1984

The opinions rendered by the Council are intended as guides to responsible professional behavior, but they are not presented as the sole or only route to medical morality. An attempt is made to relate the Judicial Council's opinions to relevant principals of medical ethics in parenthesis at the end of each opinion.

Forms of Medical Practice

The purpose of this booklet of 51 pages is to briefly outline the different forms of medical practice (sole proprietorship and partnership) and the most important advantages and disadvantages of each.

AMA Reference Guide to Policy and Official Statements, 1983

AMA Cost Effectiveness Plan: 1984 and Beyond

This publication depicts the AMA's strong and long-standing commitment to private sector efforts stemming the rapid escalation of health care expenditures.

Physicians' Travel and Meeting Guide, Summer/Fall, 1984

A listing of CME meetings taking place around the country.

Talking with Patients

This is an excellent pamphlet for your office staff and phone protocol. Sometimes the words you choose describe a situation correctly, but are misunderstood by patients. For example, when you tell patients who phone the office and ask to speak with the doctor, "Sorry, the doctor cannot speak with you, he is very busy," you have communicated—. Instead of relying on patients to interpret "busy," as you meant it, you might use more specific words: "I'm sorry, Doctor is seeing a patient right now and can't come to the phone. May I take a message?"

The Environment of Medicine

This is a 105 page report of the Council on Long Range Planning and Development, December 1983. This publication takes an in-depth look at trends developing in the environment of medicine. It is highly recommended.

Tape Cassettes are available on:

Contracting—*This tape alerts physicians to some of the pitfalls in contracting. It is based on the experiences of a California physician.*

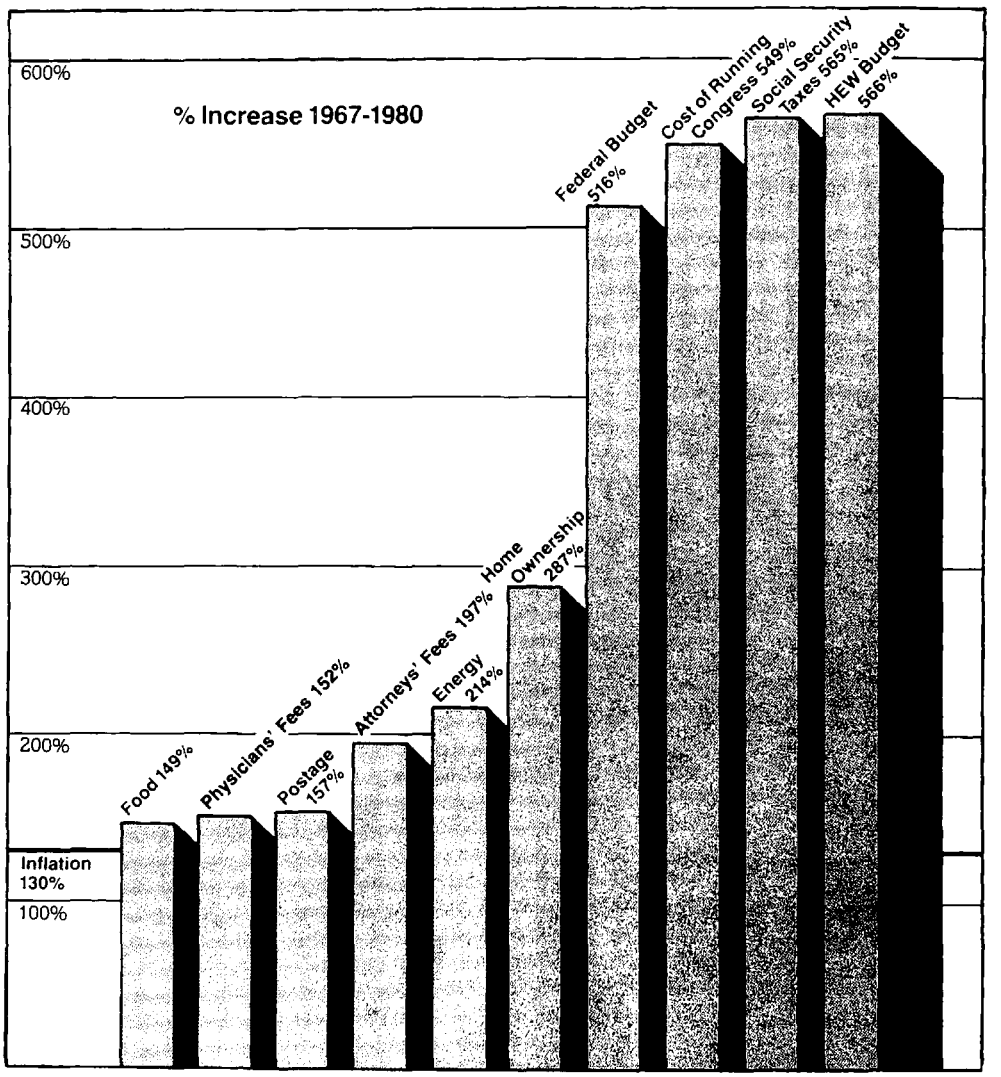
Medicine as a Private Enterprise—*This tape discusses the concept of joint venturing as it is being done in the Minneapolis area between physicians and hospitals and the future role of the For Profit hospital*

PHYSICIANS' FEES IN PERSPECTIVE

The graph below, published by the Ohio State Medical Association, illustrates the percentage increase for a physician in relationship to the cost for other non-related health items over a ten year period.

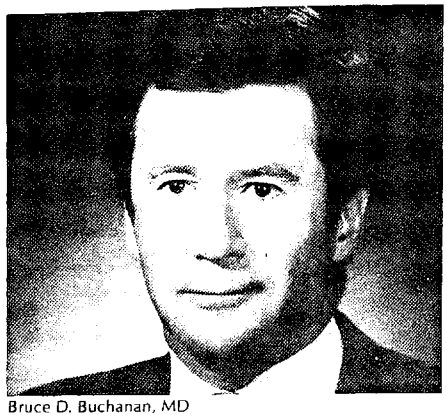
According to the Ohio State Medical Association, inflation has accounted for nearly 50 percent of the increase in health care costs over the past ten years.

The Ohio State Medical Association further notes that physicians "see over three million patients per day, and the number is expected to increase rapidly over the next two decades as the general population ages and requires more medical care."



Source: Consumer Price Index Detailed Report, Bureau of Labor Statistics, Dept. of Labor.

The following editorial information is presented by the Pierce County Medical Bureau.



Bruce D. Buchanan, MD
Chairman, Board of Trustees, Pierce County Medical Bureau

It is the perception of the current Chairman of the Board of Pierce County Medical Bureau that the Pierce County Medical Bureau has an information gap existing between practicing physicians and the entity known as the Bureau. With this in mind, space has been obtained in the Medical Society *Bulletin* to publish a series of commentaries over the next 12 months to discuss issues relative to the practice of medicine in Pierce County.

These commentaries will have served their purpose if they provide a focus for physician concerns and act as a catalyst to promote dialogue about critical issues threatening the future practice of medicine.

Although there are a variety of issues demanding to be addressed, it would first seem appropriate to discuss the heritage of the organization.

Surprising as it may seem, the Pierce County Medical Bureau was the first successful health care contractor in the United States. Local physicians formed an "open-panel" prepaid health care service in Tacoma 67 years ago. The Blue Shield plans that later formed across the nation were based on the principles that were established by the early physician members of your Pierce County Medical Bureau.

The founding physicians of the Bureau, and those who later joined as members, were not entirely motivated by altruistic goals. Quite simply, there were many physicians and too few paying patients in the Pierce County area. Joining the Bureau gave independently operating physicians a competitive edge against the "closed-panel" clinics that had garnered a substantial share of patients through contracts with the logging and shipping industries.

It seems that now we have come full circle. In recent years, the too generous proportion of local physicians to patients and the explosive cost of health care has created an atmosphere of keen competition among physicians and other providers of health care.

By comparison we are quite fortunate. Whereas our predecessors had to start from "scratch," we have a very sophisticated, multifaceted system at our disposal to insure that we will have an ongoing substantial market share of patients coming to our office.

As a group of physicians organized within the Bureau, we have the potential to exert substantial power if we can unite our wills collectively. It is for this reason I have encouraged those of you who are participants to strongly consider paying your $100 and becoming members.

The Bureau is not an insurance company. It is a nonprofit health care contractor and a business organization that employs a staff of competent, professional service people.

A Board of Trustees governs the Bureau, working closely with executive staff members and officers. The Board is comprised of nine member physicians and five public representatives. The Board is augmented by five standing committees and various *ad hoc* committees. Standing committees include the Fee Committee and the Utilization Review Committee, which can have a very direct impact on participating physicians and their practices. Since over 98% of Pierce County physicians have participating agreements with the Bureau, the influence of these Committee members has the potential to be substantial.

The Bureau currently serves approximately 40% of Pierce County's population—about 179,000 people. The Bureau contracts with groups and individuals to provide well-balanced health care and protect them from the financial crisis of major medical expenses. The Bureau also provides a supplement to the Federal government's Medicare program. In addition, the Bureau contracts with the government to administer local Part B Medicare claims. The total claims processed in 1983 was $70 million.

If issues are troubling you, they are also on the minds of your peers. The Bureau solicits your comments and input. Let us know what direction you want us to take in your future as a practicing physician in Pierce County.

I will continue to express my thoughts about the Bureau during my tenure as Chairman.

Bruce D. Buchanan, MD
Chairman, Board of Trustees, Pierce County Medical Bureau

Paid for by the Pierce County Medical Bureau

College of Medical Education
Continuing Education Programs Scheduled for 1984-85

(Programming is subject to change—individual notices will be sent preceding each program.)

Phone: 627-7137

(P) = Physician **(A)** = Allied Health

Location	Date	Program	Coordinator	
	SEPTEMBER			
	13, 14	(WSMA Annual Meeting)		
ABH	29, 80	TAIM - Retreat	Ames	(P)
JH	17, 24	Chemotherapy	Boulet	(A)
JH/MB	27, 28	Advanced Pediatric Life Support	Seward	(A)
JH	25, Oct. 2	12-Lead EKG/Pressure Waveform Analysis	Hilyard	(A)
	OCTOBER			
STH	4	Marketing—Medical Practice		(P)
STJ	9, 16, 23, 30	Nursing Pharmacology	Pelham	(A)
STJ	11	Marketing & Persuasion Skills for Nurses	Vipperman	(A)
STJ	19	Right Brain/Left Brain—increased Potential	McDonald	(P/A)
JH	24, 31	Writing on the Job	Dummond	(A)
STJ	18	Discharge Planning	Johnson	(A)
JH	24, 25	20 Most Common Diagnoses	Foss	(P)
JH	2, 9, 16, 23	Money Management Strategy	Jackman	(P)
	NOVEMBER			
JH	2	2nd Annual Cancer Education	Katterhagen	(P/A)
JH	14	Ostomies: Let's Learn About Them	Klatt/Chong	(P/A)
JH	16	Geriatrics	Munoz	(P/A)
STJ	15, 16	Survival Skills for Nurses	Dean	(A)
EX INN		Ward Secretary	Absher	(A)
STJ	29	Ethical Dilemmas	McCormick	(P/A)
	DECEMBER			
JH/MB	4, 5	Advanced Pediatric Life Support	Seward	(P)
JH	7, 8	Advanced Cardiac Life Support (Cert/Recert)	Dunn	(P/A)
	JANUARY		Wulfestieg/	
		Ear/Nose/Throat in General Practice	Rone	(P)
STJ	24	Law & Medicine	Malden	(P)
	FEBRUARY		Pomeroy/	
JH	7, 8	Orthopedics in Family Practice (includes Sports Medicine)	Bargren	(P)
		Hospital Budgeting		(A)
	MARCH			
JH	14, 15	Tacoma Academy of Internal Medicine	Ames	(P)
JH	16	Day of Pediatrics/Poisoning	Scherz	(P)
	APRIL			
UPS	12, 13	Surgical Club	Martin	(P)
STH		Neurology	Overfield	(P)
	MAY			
JH	23, 24	Cardiovascular Disease Review	Strait	(P)
	JUNE			
		TPN	Pelham	(P/A)
		Advanced Cardiac Life Support	Dunn	(P/A)

Dates are subject to change—Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and/or have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137

ETHICAL GUIDELINES FOR MEDICAL PRACTICE

The Medical Society's Board of Trustees has approved a statement of Ethical Guidelines for the Practice of Medicine in Pierce County, drafted by the Ethics/Standards of Practice Committee.

Our objective in submitting the guidelines to the Board and general membership is to provide some basic guideposts as we practice medicine in a challenging and changing environment. They are offered as a hoped-for catalyst for discussion and self-examination of the ethical foundation of our profession and how our ethics relate to the practice environment we all must deal with in the 1980s.

Many of the points contained in the guidelines reflect discussions held at our 1982 general membership meetings which were well attended and received by the membership. Other points have been added by the committee during its deliberations in recent months.

The guidelines are intended to reflect our local concerns. They are not "cast in stone" and may well be subject to future revisions as time and circumstances dictate. Your comments and suggestions are welcomed.

Due to the numerous requests we have received for the Ethical Guidelines for Medical Practice since the first publication in November, 1983, we are reprinting the Guidelines as a special insert in this month's issue of The Bulletin. You will note, there has been one addition to the Guidelines: Marketing Practices for Hospitals.

-Gilbert J. Roller, MD,
Chairman, Ethics/Standards of Practice Committee

As stated in the preamble to the Principles of Medical Ethics established by the American Medical Association (AMA), the medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsiblity, not only to patients, but also to society, to other health professionals, and to self.

The following guidelines for the practice of medicine in Pierce County are based on reports and opinions of the AMA and Washington State Medical Association (WSMA) Judicial Councils, as well as the Principles of Medical Ethics. In some instances they have been rephrased, with emphasis added, to reflect local concerns.

They are not meant to supplant opinions defined by the WSMA or AMA. They are offered as standards of conduct which address issues of particular interest in Pierce County in the 1980s, and they are intended to be applicable to all physicians and surgeons, regardless of their practice setting, since ethical concerns affect all who enter the profession of medicine. For the sake of brevity, pronouns of masculine gender apply to both male and female physicians. Your comments and suggestions for future revisions of these guidelines are welcomed.

Advertising versus Solicitation

The Principles of Medical Ethics and Washington State law regarding unprofessional practice as it relates to advertising are intended to discourage abusive practices that exploit patients, the public and interfere with freedom in making an informed choice of physicians.

Advertising per se is not unethical. Advertising means the action of making information or intention known to the public.

Solicitation means the attempt to obtain patients by persuasion or influence, using statements or claims that contain testimonials, are intended or likely to create inflated or unjustified expectations of favorable results, are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice, imply that his standard of care is superior, or contain incorrect facts or representations or implications that are likely to cause the average person to misunderstand or be deceived.

Solicitation is unethical.

Marketing Practice of Hospitals and Clinics

Marketing practices of hospitals and clinics involving participating physicians should conform to the ethical guidelines of the Medical Society of Pierce County.

Call Coverage

Access to a patient's physician is not to be compromised. Call coverage must be arranged so that patients, clinics, hospitals, and emergency rooms can readily locate physicians or their covering colleagues. Call coverage should be similar in scope; that is, it should represent a level of care consistent with that provided by the patient's physician. Freestanding clinics should provide call coverage during the hours they are not open.

Communication

When more than one physician has been involved in the care of a given patient, each involved physician should carefully communicate to each of the other involved physicians information available to him which may affect understanding of the patient's condition and care. Transmittal of information is with permission of the patient.

Competition

Ethical medical practice thrives best under free market conditions when prospective patients have adequate information and opportunity to choose freely among competing physicians in alternate systems of medical care.

Emergency Care

When emergency care is provided by a physician or source other than the patient's primary care physician, records of this care should be provided to the primary care physician if the patient desires. The physician or provider of care should ask the patient if he desires that his records be so provided. In all cases, the provision of care under urgent or emergency circumstances should be performed in a manner that respects and supports the concept of continuity of care, and the patient's relationship with his primary physician.

Fees

Fee splitting in any form is unethical behavior and is not to be tolerated. Fees charged by physicians should not be excessive when compared with charges by similar physicians in the area, in the state, and in the region for similar services.

Freestanding Clinics

Freestanding "convenience care" or "urgent care" clinics are not an unethical practice of medicine, provided the physicians associated with such clinics adhere to the Principles of Medical Ethics and Standards of Care as established by the Medical Society of Pierce County, Washington. State Medical Association and American Medical Association, and the current opinions of the Judicial Councils of the AMA and WSMA.

The ethical principles actuating and governing a group or clinic are the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the Principles of Medical Ethics, the establishment of a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

Medical Records

Physicians should honor all requests of a person who is or has been a patient, and the requests of a medical representative of that patient under appropriate written authorization, to inspect his medical record, and to receive a copy thereof for a reasonable fee. Such access should be withheld only in those cases where prohibited by law, or where, for psychiatric or other medical reasons in the judgment of the patient's attending physician, such release would be detrimental to the patient. Under those conditions, access should only be pursuant to an order of the court.

It is unethical for a physician, who formerly treated a patient, to refuse for any reason to make his records of that patient promptly available on request to another physician presently treating the patient.

It is unethical to withhold transfer of medical records or provision of a copy of medical records for medical care purposes because of an unpaid bill for medical services.

Physician Conflict and Standards of Care

A question regarding a physician's standards of care should be referred to an appropriately empowered committee of the Medical Society of Pierce County or hospital medical staff committee for initial review. When actual or potential conflict between physicians arises, verbal communication as an initial attempt to resolve the conflict is preferred to written communications.

Physician-Physician Relations

The need for assistance at a surgical procedure should ordinarily be determined by the physician in charge of the surgical procedure. If medically indicated, pre- and postoperative care of the patient undergoing a surgical procedure should include the services of the primary care physician. The sharing of responsibility in this area requires communication between the primary and consulting physicians.

Physician's Professional Obligations to the Community

Physicians should recognize the responsibilities of participating in activities to promote an improved community. Physicians should willingly serve on boards and committees of the Medical Society and other medical organizations of which they are members and should work to make such organizations responsive to the needs of the profession and community.

Physician Responsibility

Each physician has the responsibility to provide care, to the best of his ability, for the problems of all patients accepted into his practice. This includes arranging for a consultation to provide or assist in the care of those problems which are outside the scope of his practice or in which satisfactory progress of diagnosis or treatment is in doubt. Any consultation should be coordinated with the primary physician.

Restraint of Trade

Restraint of trade is unethical and illegal. Nothing in these guidelines is intended to imply restraint of trade.

The Right to Optimal Care

All patients should have available to them a primary physician or source of care. Willingness to see all patients without regard to their ability to pay is encouraged and is in keeping with the highest ethical principles of the practice of medicine. Care provided by the primary physician should emphasize continuity, including appropriate follow-up of all conditions under treatment and a systematic program of preventive care according to standards accepted by the profession locally. Primary care should also be comprehensive, addressing all aspects of the patient's physical, mental and emotional health in an appropriate manner.

Transfer of Care

Whenever a patient transfers his medical care from one physician or provider of care to another, the physician or provider from whom care is transferred should readily provide relevant medical information to the new physician or provider of care. A reasonable charge related to supplies and copying time may be made.

AUXILIARY NEWS

Up-Coming Year Promises to be Exciting

The up-coming year promises to be an exciting one. We have plans for interests groups to meet, new community project involvement, a variety of speakers scheduled and possible day trips to Seattle's garment district and a visit to the County-City Building.

Look for details in *The Bulletin* and newsletter. Come join us!

WSMSA Convention Scheduled for Sept. 13 and 14

The Washington State Medical Society Auxiliary Convention will be held at the Westin Hotel, Seattle, September 13 and 14. "Preventative Medicine in the 80s" is the topic of Dr. John Robertson's address. The luncheon following his presentation will reflect the principles he develops in his talk.

Dr. Robertson trained with Dr. Kenneth Cooper in Dallas, Texas, and is currently practicing in Seattle at the Sports Medicine clinic.

Also speaking will be Hedda Sharapan, Associate Producer of *Mister Roger's Neighborhood.* She will discuss the effects of the electronic media–TV, video games and computers. Emphasis will be directed toward methods to enhance the positive aspects of the media and minimize the negative.

On Thursday afternoon new advances in organ donation and new legislation governing organ transplants will be presented.

Contact Sharon Ann Lawson for additional information on the schedule or to arrange car pooling. Hope to see you in Seattle!

General Membership Meeting: September 21

The first General Membership Meeting of the Pierce County Medical Society Auxiliary will be held September 21 in the Great Hall, at Annie Wright. Highlight of the program will be a performance of the Annie Wright Chorus and a slide presentation by Marion Staatz on Centennial Tacoma.

A short meeting is scheduled to welcome the Newcomers and acquaint everyone with current projects and the new extras available to members. For your convenience the schedule of events will be printed in the newsletter.

Sharon Ann Lawson Attends AMA Convention

Sharon Ann Lawson attended the AMA convention in Chicago as a delegate from Washington. Pre-and post-natal care programs were discussed during the mini briefing session on health projects to give leaders ideas for implementing community health education on these topics. This is the major thrust of the umbrella program, *"Shape Up for Life in 1984-85."*

The legislative session focused on the auxilian as a lobbyist and provided clear, simple ways to be effective.

The audio-tape is available through Sharon.

Applications for PCMSA Philanthropic Funds Due September 15

All applications for the PCMS Auxiliary Philanthropic funds must be submitted by September 15, 1984. A complete list of applicants will be printed in the October newsletter for members review and information.

Please direct any questions or comments on the applicants to Jo Roller, Finance Chairman, by November 30.

Thank you.

Jo Roller, Finance Chairman

Auxiliary News, continued on page 16

PCMSA Takes Active Part in Seatbelt Program

A great deal of networking has been going on among volunteer organizations and governmental departments at all levels to create a successful seatbelt program. The result is an international program that is using the logo pictured

Posters, street signs and other printed materials are being used in educational programs. Our members have been busy distributing posters throughout the county. The Auxiliary is proud to be a part of this program.

Auxiliary General Membership Meeting: Oct. 19, Sheraton Hotel

The October 19 Membership Meeting will be held at the Sheraton Hotel. Tickets for this special event are limited, so be sure to check you newsletter for all the details.

Auxiliary News,
continued on page 22

HOSPITAL NEWS

In an effort to improve communication within the medical community The Bulletin will be publishing news of consequence on the hospital scene in upcoming issues.

—the editor

Good Samaritan

Good Samaritan Hospital Receives Grant for Cancer Registry

Good Samaritan Hospital received a $5,000 grant from the Florence Kilworth Foundation and a $2,200 grant from Pacific Northwest Bell to assist with the costs of establishing a cancer registry.

The cancer registry program increases the quality of cancer treatment provided in Good Samaritan Hospital and assures that patients receive a coordinated, continuity of care.

The more immediate benefit to patients results from the fact that the registry and American College of Surgeon's accrediation helps attract cancer specialists to the Puyallup Valley. This means that patients can come to Good Samaritan Hospital rather than travel to hospitals in Seattle and Tacoma for treatment—a saving of time and travel expense as well as reducing family stresses.

The cancer registry involves the collection, management and analysis of data on persons with a diagnosis of cancer. This data includes the ongoing records of the cancer patient's history, diagnosis, therapy and outcome. The tumor registrar, who maintains the registry, works closely with physicians, hospital administrators and health care planners to maintain detailed records.

Education, life-time patient follow-up, and research are the three important reasons for the maintenance of a cancer registry. The availability of statistical reports enable physicians to evaluate the successes of specific treatment patterns: and the data collected serves as a valuable resource for researchers interested in the causes, diagnosis and treatment of cancer.

A Good Samaritan Cancer Fund has been established so that interested community members can help sponsor this necessary and worthwhile endeavor. Donations should be sent to the GSH Development Office, Post Office Box 1247, Puyallup, WA 98371.

From: "Update," Good Samaritan Hospital, Puyallup, WA.

Lakewood General

Lakewood General Hospital Seeks Approval for Adolescent Substance Abuse Program

Lakewood General Hospital is planning to establish a 27-bed alcohol and chemical substance abuse unit for adolescents.

The *New Beginnings* treatment program will begin service during the month of October, pending approval of a certificate of need by the Washington State Department of Social and Health Services, the Washington State Hospital Commission, and the Puget Sound Health Systems Agency. The *New Beginnings* program will be geared toward young people between the ages of 12 and 18 who are having problems with drugs or alcohol. The length of stay in the unit will range from 30 to 45 days; post-discharge follow-up care will be provided.

The *New Beginnings* program will involve physicians, psychologists, therapists and counselors. It will include evaluation and medical management of the adolescent as well as rehabilitation and aftercare.

The *New Beginnings* program will be directed and managed by Recovery Centers of America, a subsidiary of National Medical Enterprises. Recovery Centers of America directs and manages a number of other alcohol and chemical substance abuse units throughout the United States.

"Recent national studies show that with appropriate treatment, two out of every three chemically dependent persons return to active, normal lives," said Bruce M. Yeats, Chief Executive Officer of Lakewood General.

"Throughout the adolescent *New Beginnings* program, there is emphasis on family involvement in the recovery process. In addition, the program draws upon significant community resources," he added.

Persons interested in finding out further information about the *New Beginnings* program can call 588-1711, ext. 218.

Lakewood General Hospital to Build New Hospital

The Board of Directors of Lakewood General Hospital has approved submission of a certificate of need to construct a new 95-bed hospital at 112th and Bridgeport Way Southwest in Lakewood.

The new hospital will cost approximately $17 million. Early planning indicates that the building will have approximately 101,500 sq. ft. of space. The certificate of need, a proposal describing the project, now goes to the Washington State Department of Social and Health Services, the Washington State Hospital Commission and Puget Sound Health Systems Agency for their approval.

Cadem Corporation of Tacoma, a health services development firm, has

Hospital News, continued on page 19

MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Robert F. Wachtel MD, *General and Emergency medicine.* Born in New York, 9/3/50; medical school, Boston Univ. School of Medicine, 1975; internship, Tucson Hospital's Medical Education Program; Washington State License, 1976. Dr. Wachtel is currently practicing at 4020 South Steele Street, Tacoma, WA.

Matthew Rice, MD, *Emergency Medicine.* Born in Bloomfield, Pa., 6/17/49; medical school, Pennsylvania State Univ., Hershey Medical Center, June 1977; internship, Tripler AMC, 6/77-7/78; residency, Brooke Army Medical Center, 6/81-7/83; Washington State License, August, 1983. Dr. Rice is currently practicing at Madigan AMC, Tacoma, WA.

Philip C. Craven, MD, *Internal Medicine and Infectious diseases.* Born in Washington D.C., 2/7/44; medical school, Johns Hopkins Univ. School of Medicine, 1969; internship, San Francisco General Hospital, 6/69-6/70; residency, Univ. California in San Francisco, 7/70-6/71 and San Francisco General Hospital, 7/74-6/75; fellowship—infectious diseases, Univ. Texas Health Science Center, 7/75-6/77. Washington State License pending. Dr. Craven is currently practicing at 1624 South "I" Street, Tacoma, WA.

Hospital News,
continued from page 17

been selected by the hospital to coordinate development of the new hospital and the surrounding health-care campus. Cadem is a subsidiary of National Medical Enterprises, Inc.

"The new hospital will be designed with the patient in mind by providing all private rooms," said Bruce M. Yeats, Chief Executive Officer of Lakewood General. "Additionally, it will be designed to achieve a high level of operating efficiency and cost effective health-care delivery."

Under the current plan, construction of the new hospital will begin within 15 months on the 23-acre health-care campus site. The new hospital will continue to offer acute medical and surgical care as well as specialty care in intensive care, coronary care and obstetrics.

Wallace A. LaBrie, Chairman of the Board of Directors of Lakewood General Hospital, emphasized that the Board is viewing the new hospital site as a "health campus" which will promote continuity of health service provision by including such other services as a medical office building, a nursing home and retail medical businesses.

"We are encouraged by the clear indication that other health providers are interested in developing the health campus," LaBrie said.

St. Joseph

Major Construction Alterations Underway at St. Joseph

St. Joseph is in the process of undergoing some major construction alterations. Final completion is scheduled for March '85.

The South Pavilion Tower renovation is targeted for completion by Christmas. Major alterations are underway on the first floor of the main hospital building. The former dietary dry storage and storeroom areas are being demolished to make way for enlarged linen and distribution departments and a corridor connecting the South Pavilion and the service elevator lobby.

Hospital News,
continued on page 22

CLASSIFIED

Emergency Room, Urgent Care Physicians—Immediate opportunities with the largest Northwest emergency medical group. Choose your own location, schedule, earnings potential. Eastern, Western Washington, Oregon. Contact: L. Poschman, Physician Services, Northwest Emergency Physicians, 11808 Northrup Way, Bellevue, WA 98005, (206) 828-6799.

Family Physicians Needed—for suburban community clinics in South King County. Full and part-time positions. Provision of direct patient care. Regular hours, Monday thru Friday. No call at present. Washington State medical licensure required. Board certification in family practice desirable. Contact: Molly Lanegraff, Clinic Coordinator, Valley Community Clinic, 1025 S. 3rd, Renton, WA 98055, (206) 226-7039

Lakewood—1,500 sq. ft. Medical Dental Bldg. Good location for dental specialists. High visibility. Call Dr. Kenneth P. Ring 584-6200.

Lakewood General Practice Opportunity—Lease the space; start practice with many referrals. Call: 473-7303.

View Home: Gig Harbor—Now $120,000 by owner. I've slashed $16,000 off the price on this 2,800 sq. ft., 3 bedroom home with many amenities. Must sell by summer. Call George: 1-851-5248.

The **Emergency Medical Services Division** of Tacoma-Pierce County Health Department is seeking a physician to serve as an EMS training physician. Applicants may anticipate working approximately 32 hrs. per month in a paid consultant capacity providing medical direction and training to students enrolled in the Tacoma Community College EMS training program. Resumes must be submitted to the EMS Division, Tacoma-Pierce County Health Department, 420 S. Fawcett, Tacoma, WA 98402, by Sept. 15, 1984. Phone (206) 591-5747.

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A Member of The Manor HealthCare Community.

Hospital News,
continued from page 19

Kitchen refrigeration capacity will be increased by mid-August along with CRS renovation. The gift shop and admitting area are also scheduled for a face lift.

Construction workers will start demolition proceedings by September 20 on the second floor of the main building. Medical Records will be converted into a larger employee Snack Bar. Radiology will be expanded to include what is now the Pharmacy Department. The surgeons' locker rooms and lounge will be enlarged into the present nurses' lounge.

Renovation of C-quad into an Open Heart Recovery Unit is scheduled between August and mid-October. The nursery will be moving from A-quad to the center core with a 22-bassinet capability.

Construction coordinator Neil Heyman says construction activity is planned for the least amount of interruption in the hospital services.■

Auxiliary News,
continued from page 16

New Auxiliary Project Under Consideration

A proposal for undertaking a community project to work with new parents and their children is being considered by the PCMSA Board. A two-part program, the first part would focus on recruiting parents of children ages zero to three to participate in an effective parenting program. The second part of the program involves development of a drop-in facility for parents to meet, share experiences, request specific parenting information classes and gain self confidence.

This type of support encourages the parents to develop their own support systems by networking with other parents at the center.

Because of the scope of the program, the Auxiliary would work closely with the existing county program, *The Family; Birth to Three*, parent support program. The staff is excited about the prospects of working with the Auxiliary and has offered to train volunteers for the program.

This type of program offers us the opportunity to provide positive and preventative health information to a segment of our population that has the greatest need for assistance. Children are our greatest resource. If you are interested in seeing the Auxiliary get involved in this area and would like to volunteer, contact any Board member.

Auxiliary Newsletter Scheduled for Circulation

Any day now you should receive your copy of our newsletter. This first monthly newsletter outlines the activities planned for the 1984-85 Auxiliary year. You will want to read about the special events that have been scheduled for the up-coming year.

If you do not receive your letter, call Marilyn Bodily, Helen Whitney, Alice Wilhyde or Sandy Shrewsbury to verify your address listing. Keep informed so you don't miss out!

Contact Terri Stewart, 1-851-2578, with news items for subsequent newsletters by the 23rd of each month. You should receive your letter at the beginning of each month.

Auxiliary News,
continued on page 23

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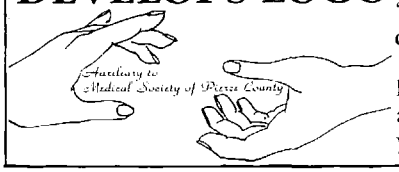
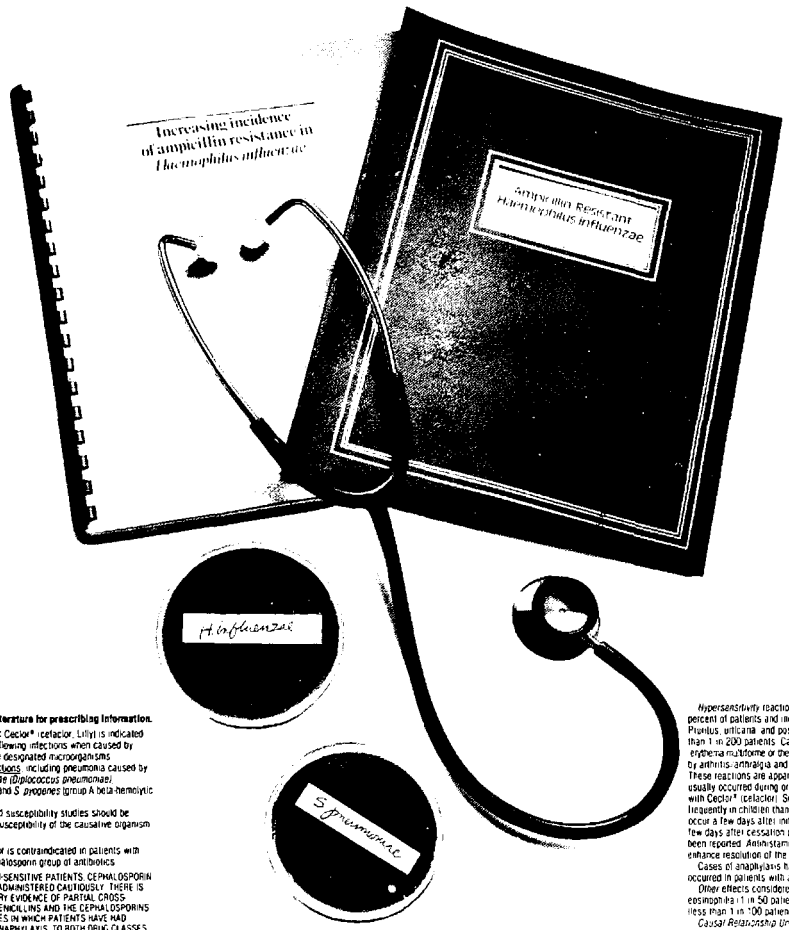
COUNTY MEDICAL AUXILIARY DEVELOPS LOGO



Your county Medical Auxiliary has its own identifying symbol thanks to Nikki Crowley and Renee Pavey. Renee, immediate past president of WSMAA, graciously shared her theme of the "helping hands" with Nikki so that she could create this county logo.

Wherever you see these helping hands, you will know that your county auxiliary is at work. Feel proud! Thank you, Nikki.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindications: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and frequently fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(1006H)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett): p 487. New York: John Wiley & Sons, 1979.

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

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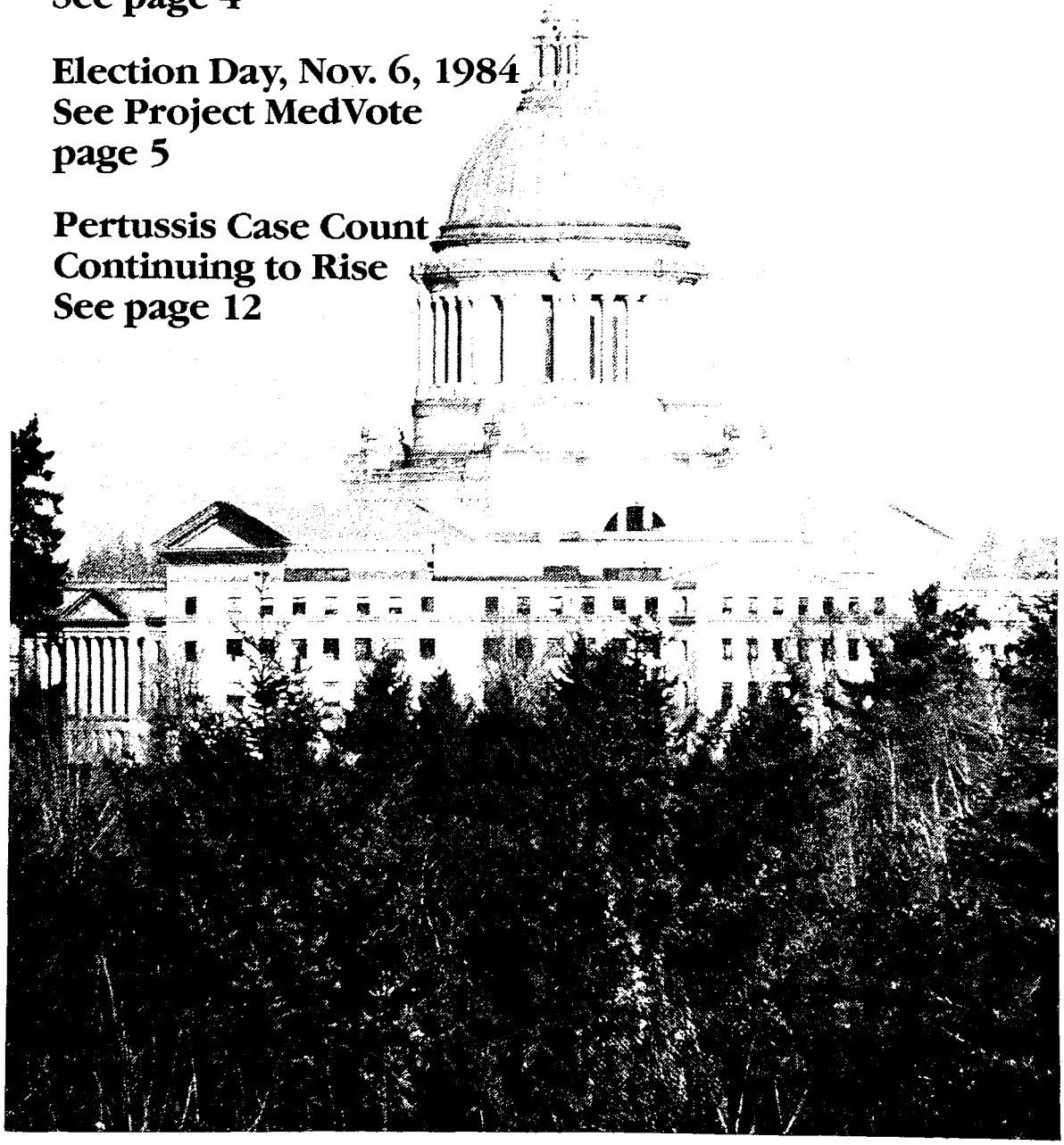
The Bulletin
MEDICAL SOCIETY OF PIERCE COUNTY

October, 1984

A Physician's Dilemma: Professional Vs. Business Ethics
See page 4

Election Day, Nov. 6, 1984
See Project MedVote page 5

Pertussis Case Count Continuing to Rise
See page 12



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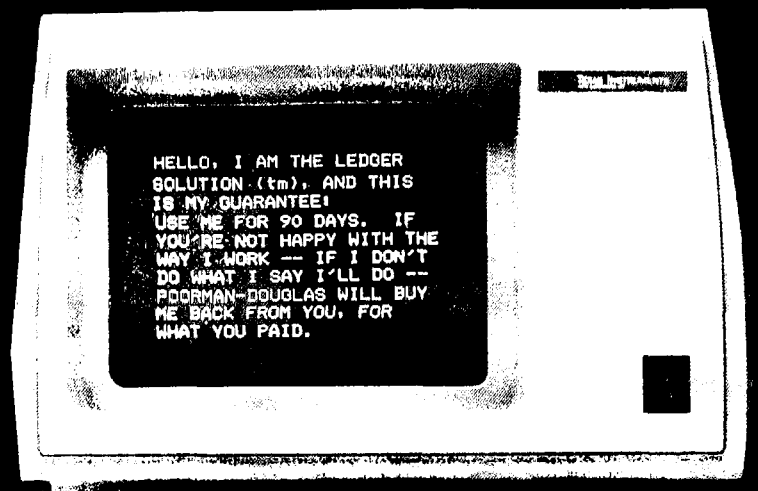

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In This Issue

Cover Photo: State Capitol, Olympia, Washington

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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President's Page

A Physician's Dilemma: Professional VS. Business Ethics

In a recent, and all too rare (!) moment of relaxation, I had the opportunity to read for a second time the inaugural address of Joseph F. Boyle, MD, president of the American Medical Association. The ethical issues he discusses in the address prompt me to make his remarks a President's Page priority.

I encourage each of you to read the complete text of this address, printed in the August 10, 1984, issue of the *Journal of the American Medical Association*. In the meantime, I shall extract some of the key points on Dr. Boyle's theme, *"Should we learn to say no to our patients?"*

For 2,000 years, doctors have dedicated themselves to a code of ethics perhaps best summed up by two statements of the World Medical Association:

"The health and welfare of the patient shall be the first consideration, not allowing economics, politics, race or religion, or any other circumstances to take preference.

"While physicians should be conscious of cost, and not provide or prescribe unnecessary services, social policy expects that concern for the care of the patient will be the physician's first consideration."

How do these statements translate into our daily practice of medicine? At what cost?

A report from the Brookings Institution, contained in the book, *The Painful Prescription*, may give us some answers. The report compares the system of medical care in the United Kingdom and the United States. It states conclusively that, if the United Kingdom standards were applied to patients in the U.S., there would be no fewer than 37,000 excess deaths a year from renal disease, 48,000 from cancer, and 40,000 from coronary artery disease. An additional 138,000 people would be denied the extension of a useful, productive and comfortable life—and that is just some of it.

Of critical importance to this country's physicians, according to Dr. Boyle, is the report's assessment of the attitudes of the United Kingdom's physicians. Physicians there, he says, gradually refine standards of care so that they can escape the constant recognition that financial limits compel them to do less than their best. One consultant noted, "The physician has to look at the arguments for **not** treating a patient in order for the doctor to live with himself and to sleep well at night."

In the past 20 years, we in the United States have been searching for means to assure access and availability of high-quality medical care and hospital services to every person in the country. For nearly half of those years, we have struggled with a counterveiling question: How can we reduce the escalation in cost of care and promote economy and efficiency in the provision of health care services? How can we best limit access, decrease demand and ration care?

In order to avoid such retrenchment, Dr. Boyle urges physicians to rededicate themselves to their professional ethics.

"This means behaving like professionals in a profession that believes in itself," he says, "and that believes in its future. It does not mean succumbing to the business world, seeking means to enhance profits for personal wealth. It **does** mean seeking ways to provide good care for all those who entrust their lives and well-being to us."

Contrast these ethics to the advice we are now receiving from marketing experts, entrepreneurs seeking membership in PPOs, economists and, unfortunately, a growing number of our own physicians. They say that, instead of adhering to the Oath of Hippocrates (wherein it states that physicians have a primary responsibility to the individual patient), we should adopt a business ethic: Get your share.

How do we, as chief health providers, resolve this dilemma between professional and business ethics? Professor of Economics Uwe Reinhardt, of Princeton University, illustrates the poignancy of the question:

"I advise my students that when they are in business, they should consider themselves in a race. In that circumstance—a 100-yard dash, for example—it might be nice social policy to pick up a candy wrapper on the track, but you'd not be likely to win many races. And in business, you do not pick up social trash along the way, not if you intend to win."

So how do we, as physicians, adhere to the principles of our profession in this regard? How do we resolve the dilemma when, because of DGR reimbursement or other resource limits, we are pressed either to discharge patients from the hospital prematurely or not admit some patients to a hospital at all?

And there are other pressures as well, many imposed on us by the Federal Trade Commission and the U.S. Department of Justice, Anti-Trust Division. These agencies say they do not desire to interfere with our profession's need to establish standards of professional conduct, designed to protect the public from fraudulent practices. But, as Dr. Boyle points out, in every instance, caveats are added that preclude medical societies from imposing sanctions on members who practice blatant quackery; habitually overcharge; practice beyond the scope of their clinical training, experience or competence; or promote themselves as providers of diagnostic and treatment modalities that have no scientific basis—and may even be dangerous and potentially fatal. And all of this in the name of competition.

"The net of all this fuss and fury," insists President Boyle, "has produced a loss of professional self-esteem, a decrease in our adherence to ethical standards, and a concomitant precipitous

Continued on page 7

LOCAL NEWSBRIEFS

MSPC Board of Trustees has Annual Retreat

The MSPC Board of Trustees with MSPC/WSMA Trustees, Drs. Ralph Johnson, David Hopkins, WSMA Speaker of the House, Stan Tuell and Dr. Leonard Alenick, President Pierce County Ophthalmology Association met on August 18, at the Westwater Inn, Olympia, to develop and prioritize goals for the Society to work toward in 1985.

After much deliberation, the group developed the following goals for the Medical Society in the priority as listed:

1) *Establish the Medical Society of Pierce County as a spokesman and leader for all segments of medicine in Pierce County.*
2) *Maintain high standards of ethics and professionalism in medical care in Pierce County.*
3) *Increase physician awareness of and participation with the forces changing health care delivery.*
4) *Enhance relations and cooperation between physicians and hospitals—their administrations and boards—and between physicians and hospital staffs; build bridges to direct and assist in the delivery of quality and appropriate medical services to the community.*
5) *Launch an aggressive program to contain the cost of medical care while ensuring the quality of such care.*
6) *Take definitive stands on local health and environmental issues.*
7) *Increase membership and participation in MSPC activities.*
8) *Establish a strong program to increase public awareness of MSPC and its concern for the public's health and welfare.*

The strategies and programs necessary to accomplish these goals are being developed and will be presented to the Board for approval.

MSPC Calls Special Meeting to Discuss Medicare Reimbursement Plan

The Deficit Reduction Act of 1984, briefly discussed on page 6 in the September issue of *The Bulletin*, has created the "participating" and "non-participating" physician. Each physician will have had to decide whether to participate or not by October 1.

As the September issue of *The Bulletin* was going to press, MSPC called a special informational meeting for all members regarding the new Medicare reimbursement plan. The August 30 meeting was organized to help answer the many questions left unanswered concerning the reimbursement plan. Speakers from the Health Care Financing Administration and Pierce County Medical Bureau were present to answer the questions and concerns of Pierce County physicians.

Medical Library Moves

The Pierce County Medical Library will move to a new permanent location at the opposite end from our current location on the third floor beyond the conference dining room.

The library will be moving between October 1 and October 19, 1984. Please request only minimal services or emergency related assistance from October 10 to October 14. The library will be closed from October 15 through October 19. Telephones will be installed October 18 and 19.

"Open House" will be held between October 22 and 26. Your invitations will be mailed to you.

Project MedVote

MSPC Gears Up for Voter Registration Drive

The AMA, WSMA and all County Medical Societies and Auxiliaries are joining in an effort to have 100% of the members of the medical family registered to vote. Several state medical auxiliaries have been involved with determining the number of physicians registered to vote. They found only 60% of their membership were registered. We do not know what the statistics are for Washington State or Pierce County.

The 1984 general election is critical to the manner in which medicine will be practiced in this country. Every vote counts. During September and October you will see members of the Pierce County Medical Society Auxiliary staffing voter registration tables in hospital lobbies and near the physician lounges. Legislative Chairperson, Sandy Griffith, and her volunteers have been deputized to register voters. If you have not registered, do so now. Your future depends upon it.

Local Newsbriefs continued on page 6

Local Newsbriefs, continued from page 5

Health Department Asks Drs to Report Whooping Cough Cases

Tacoma-Pierce County Health Department is asking all Whooping Cough cases to be reported to the Health Department. Those with chronic paroxysmal cough and low grade or no fever should be reported. Protocol for pertussis specimen collections and media for testing is available at the Tacoma-Pierce County Health Department, Communicable Disease Section, 591-6410. For an update and further information see Dr. Bud Nicola's report on page 10 in this months issue of *The Bulletin*.

Hazards of Marijuana Smoking Discussed at All Day Seminar Oct. 12

The American Lung Association of Washington will present an all day seminar October 12, 1984, from 8:00 A.M. to 3:30 P.M. at Tacoma Public School Central Building, 4th Floor, Auditorium, concerning the dangers of marijuana smoking to the lungs.

According to the Lung Association, the potency of marijuana has increased nearly ten-fold during the past ten years, which makes its smoking a health problem of major national concern with severe health consequences to users.

Open to nurses, teachers, youth leaders and parents, the seminar is aimed at increasing participant knowledge of issues surrounding marijuana use.

Continuing education credit for Washington State nurses and perdiem pay for Tacoma Public School teachers is available.

For more information or to register: call the Lung Association, Tacoma, 474-9547 or toll free 1-800-732-9339.

Effective November 26, 1984 Drs. Wouter Bosch, Arthur Ozolin, John Stewart and Galen Hoover will be located at 2420 S. Union, Suite 300. Phone number will be: 756-0888.

China Exhibit Tour Big Success

Nearly 100 members and spouses took advantage of the Society and Auxiliary's offering for a trip to the Seattle Center and tour of the China Exhibit.

Special thanks go to Dr. Bob Lane for the idea, Sharon Lawson for planning and organizing the trip and Society office staff for managing the administrative details.

Continued from the President's Page, A Physician's Dilemma: Professional Vs. Business Ethics

decline in public confidence—and this in a time when the public cries out that it needs to believe in its institutions."

None of us, alone, can resolve these inherent conflicts. But we **can** do something as a profession. Once again, I quote AMA President Boyle:

"We have an opportunity as a profession to regain the public's esteem if we are willing to accept the task of leading—leading a restoration of simple morality in society, beginning with ourselves. And we can accomplish this beginning with a rededication to a professional ethic.

"Why do we tolerate physicians in practice who, after contracting to have their medical educations paid for at public expense, default on their loans or their commitments to public service? Should we not insist that medical schools include a mandatory course in ethics in the curriculum, when 70% of our graduates tell us that their training has been less than adequate in this area?

"Should we not loudly and clearly be encouraging our local medical associations to seek means whereby they can review fee practices of some of their members? Are we willing to pledge substantial portions of our assets to stand behind those scientific societies willing to establish standards of practice that will protect the public from the incompetent practitioner?

"If we proceed in a deliberate and conscientious fashion, committing ourselves to an ethical standard for medical practice that is intended to serve our primary goal and to protect the interest of individual patients, then we will have taken a long step along the path that leads to real progress in medicine, instead of retreating into mediocrity."

I suggest, as does Dr. Boyle, that the choice is yours, as it is mine. *—JPD*

Tel-Med Contributions Assure Continuation of Tel-Med

The Tel-Med Board, volunteers and staff extend their appreciation for the generosity of the members whose contributions have made the continuation of Tel-Med possible. Thank you!

Clarence Anderson, MD
Leo Annest, MD
Lon Annest, MD
W. Ben Blackett, MD
Milton Bleiweis, MD
Stanley Bloustine, MD
Robert Bond, MD
Otis Bridgeford, MD
Thomas Brown, MD
David Brown, MD
Donald Carlyle, MD
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Wing Chan, MD
Robert Crabill, MD
Alberto Devera, MD
Patrick Donley, MD
Duffy/Diller/Leitz
Robert Ferguson, MD
Robert Freeman, MD
Charles Galbraith, MD
Douglas Gant, MD
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Myra Vozenilek, MD
Donald Weber, MD
George Weis, MD
Robert Whitney, MD
Carl Wulfesteig, MD
Ivan Zbaraschuk, MD

Team Building

By Dolores Lunstrum, Owner, Management Resourses

Webster's Dictionary defines team as "to join together in cooperative activity."

As we watched the Summer Olympics recently I was impressed with the marvelous performance of the volleyball and basketball teams. No one person was all important. The game could not have been won without the help, cooperation and dedication of all the members of the team.

You, the physician, are the captain of the team. But you aren't the whole team. You cannot win the game, or run your practice smoothly by yourself. You need the support and help of all the members of your team.

"Few people can become successful unless a lot of other people help them to be." (Charles Brower)

Teamwork starts in the mind of the employer. Stress priorities when assigning work. Make certain that everyone in your office knows exactly what goals you have set for your practice, that you and all the staff are striving together for a common purpose.

You often have to show people how they can help one another, how they can work together for the good of the entire office. Let them know that you care not only about how well they perform their own jobs, but also how well they work together and help each other. Management consultants advise job descriptions and individual job responsibilities, but it is also important for your staff to be trained to pitch in and help one another when the need arises.

Make certain that each person realizes how important their job is to the success of the practice. Tell them . . . . again and again . . . . that what they do is indispensable to a smooth running office. If the filing is not done accurately and on time, your charts are not complete and your day does not run smoothly.

"I have yet to find a person who did not do better work or put forth greater effort under a spirit of approval than under the spirit of criticism." (Charles Schwab)

One thing that most of us resent is being told that we have done something wrong. Criticism hurts employees' morale, damages their feelings, and lowers their self-esteem. Praise is much more welcome and effective.

When criticism becomes necessary, and it certainly will, consider the following points before approaching your staff member:

- Talk it over with the person directly involved, not with other people.
- Ask questions first, don't accuse until you hear both sides of the story.
- Always speak to the employee alone. Nothing is quite so upsetting as to be corrected in front of fellow employees or patients.
- Pick the time carefully, harsh criticism early in the morning can affect the employee's performance for the rest of the day.
- If the mistake is important and has made you angry, cool off first, don't say things you will be sorry for later.
- Explain exactly what the problem is, what has caused you dissatisfaction, and how you would prefer that the situation be handled in the future. Your employees can't read your mind, you must state your expectations clearly.
- Before you point out the error, let the employee know you appreciate the things that have been done well, that you are dissatisfied with the particular action, not with the person.

Remember, the purpose of critcism is not to make employees feel discouraged, but rather to insure better performance next time. If you treat employees as important members of your team they are more likely to start being one. ■

Information for this article was taken from: *"Front Line Management"*

Continuing Medical Education in Our Community

By
David M. Brown, MD, Chairman, Committee for Continuing Medical Education

I was asked in January by Pat Duffy to chair the Committee for Continuing Medical Education of the Medical Society of Pierce County and to sit on the Board of Directors of the College of Medical Education, which is the facilitating arm of the Committee. I was flattered by the confidence which David McCowen showed in my abilities by recommending me as his successor. I saw this as a challenge to assist in meeting the needs of my colleagues for continuing medical education and as an opportunity to develop some of my own ideas.

After selecting a committee, the first task was to determine in what areas the medical society members wanted more education and what conferences they would be most willing to attend. To accomplish this, a survey tool was developed which listed the 26 topics the committee had proposed to present within the next year or two if there was sufficient interest.

The question asked was "Would you attend a conference on . . ." with the responses being "Yes," "No," or "Maybe." This allowed the committee to see what kind of conferences everyone else was interested in attending. There were also spaces to suggest other topics of interest, to volunteer to help with one of the conferences, to volunteer to give a presentation, and to mark the days and times which would be best for attendance. Two hundred fifty physicians returned their questionnaires. This is a 40% response rate, which is really quite good. The fifteen most popular courses in order were:

1) *Practical Solutions for Common Office Problems*
2) *Neurology for the Primary Care Physician*
3) *ENT for the Primary Care Physician*
4) *Advanced Cardiac Life Support (Certification)*
5) *A.C.L.S. Recertification*
6) *Common Office Procedures*
7) *Medicine and the Law*
8) *Orthopedics in Family Practice*
9) *Evaluation and Management of Low Back Pain*
10) *Rheumatology for the Primary Care Physician*
11) *Geriatric Medicine Update*
12) *Sports Medicine*
13) *Allergy Evaluation in the Office*
14) *Premenstrual Syndrome*
15) *Holistic Medicine*

Twenty-one physicians volunteered to help coordinate one or more of our conferences, and only four were members of the Committee for continuing Medical Education. Unfortunately five of these people didn't write their names on their questionnaires, so we have no clue as to their identities. If you are one of the people who would like to work on a conference this year or next, please call Maxine Bailey at 627-7137 and let her know.

Several physicians also volunteered to give specific lectures on various topics. According to the survey, the most popular day for C.M.E. is Saturday, followed by Thursday and then Wednesday. Also, somewhat surprisingly, almost 100 physicians stated that they would prefer to attend conferences in the evenings from 6–9 P.M. If you did not have a chance to complete a questionnaire and would like to add your input to our data base please contact Maxine or Peggy at the College of Medical Education and request that you be sent a questionnaire.

The committee is planning to present ten of the fifteen most popular conferences this year, with more to follow next year.

Our first conference for the Fall is *"Practical Solutions for Common Office Problems"* to be held October 24 and 25. This will be a two-day course divided into four independent half-days for which you may enroll in any combination, according to your interests and your schedule. Jim Foss has been working very hard to put together a high quality C.M.E. program, which should be very rewarding. We expect over a hundred physicians to attend this one. In November, David Munoz is coordinating a Geriatric Medicine Conference with several nationally prominent speakers lecturing. In December, Paul Seward will be coordinating the Advanced Pediatric Life Support course and Jim Dunn will be presenting the A.C.L.S. Certification/Recertification course. I'll discuss the upcoming C.M.E. courses in a future issue.

Our committee has many talented new members who are dedicated to providing quality C.M.E. for the Medical Society of Pierce County. The list includes: Jim Foss, Jim Dunn, David Pomeroy, Mike Halstead, Mark Craddock, John Lenihan, Patrick Donley, Dennis Scholl, Keith Tucker, and Mian Anwar. The committee is also balanced by the presence of many physicians who have been active in medical education in this community for many years, including Gale Katterhagen, Bob Scherz, Dudley Houtz, Gordon Klatt, Bob Modarelli, Harold Johnston, Thomas Clark and John Lincoln.

Some of the ideas that the committee is currently pursuing include sponsoring a course in Hawaii or Mexico for 1985 or 1986, if there is sufficient interest, and purchasing some Videocassette C.M.E. programs for inexpensive rental by the Medical Society members. We are asking that individual physicians donate any Videocassette C.M.E. programs that they already own. If you are interested in participating in either of these, please contact Maxine. Another endeavor which is not a committee function, but an undertaking by some interested individuals is a Computer User's Group for Physicians so that we can all get together and demonstrate our different computers and software for each other or just come and

Continued on page 10

Continuing Medical Education in Our Community,
continued from page 9

see what other physicians are doing before we buy our own systems. If you are interested in joining such a group, please contact myself, Jim Blankenship or David Munoz.

Pierce County has a very friendly, receptive medical community with an unusually high percentage of outstanding specialists, subspecialists and primary care physicians, many of whom are also excellent speakers. This makes it easy for the College of Medical Education to sponsor high quality C.M.E., drawing almost exclusively on the talents of local people. That's good business for our community. The more we attend and support these courses, the more we all benefit.

The College has been operating on a shoestring budget for the past several years. The College was established by us and provides a great service for us, but it needs our ongoing support to survive. If every one of us decided to attend two or three conferences during the year, we could keep the College financially solvent. We should also consider contributions to the College just as we contribute to Tel-Med to keep it going.

Maxine Bailey, as many of you know, is an excellent director and she deserves this level of support. The committee is always looking for new ideas and ways of further improving the quality of our C.M.E. We also want to get as many local people involved in the activities of the College of Medical Education, so please call Maxine, myself, or any committee member with your suggestions, especially if you want to get involved. I'd like to close by thanking everyone who took the time to respond to our survey. Your interest has made it possible to better meet your educational needs and ultimately to better meet the needs of your patients. ■

College of Medical Education
Continuing Education Programs Scheduled for 1984-85

(Programming is subject to change—individual notices will be sent preceding each program.)

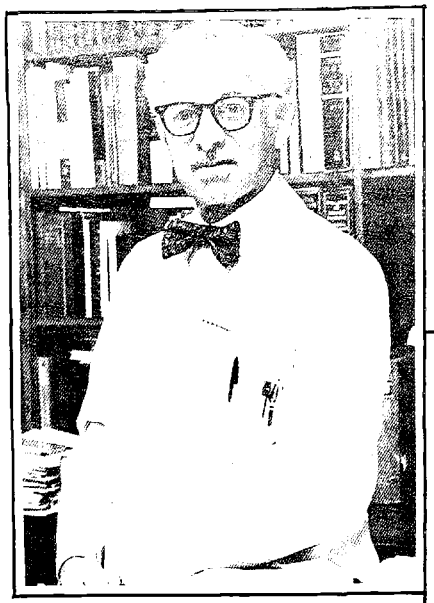
Phone: 627-7137

(P) = Physician (A) = Allied Health

Location	Date	Program	Coordinator	
	OCTOBER			
	10, 12, 17, 19, 26	Electrocardiography	Tac Gen	(P)
STJ	9, 16, 23, 30	Nursing Pharmacology	Pelham	(A)
STJ	11	Marketing & Persuasion Skills for Nurses	Vipperman	(A)
STJ	18, 25, Nov. 1	Chemotherapy	Chemo.	(A)
STJ	19	Right Brain/Left Brain—Increased Potential	McDonald	(P/A)
JH	24, 31	Writing on the Job	Dumond	(A)
STJ	18	Discharge Planning	Johnson	(A)
JH	24, 25	Practicle Solutions for Common Office Problems	Foss	(P)
JH	2, 9, 16, 23	Money Management	Jackman	(P)
	NOVEMBER			
	1	Marketing—Medical Practice	P S Hosp	(P)
JH	2	2nd Annual Cancer Education	Katterhagen	(P/A)
JH	14	Ostomies: Let's Learn About Them	Klatt/Chong	(P/A)
JH	16	Geriatrics	Munoz	(P/A)
STJ	15, 16	Survival Skills for Nurses	Dean	(A)
EX INN	TBA	Ward Secretary	Absher	(A)
STJ	29	Ethical Dilemmas	McCormick	(P/A)
	DECEMBER			
JH/MB	4, 5	Advanced Pediatric Life Support	Seward	(P)
JH	7, 8	Advanced Cardiac Life Support (Cert/Recert)	Dunn	(P/A)
	JANUARY		Wulfestieg/	
	TBA	Ear/Nose/Throat in General Practice	Rone	(P)
STJ	24	Law & Medicine	Malden	(P)
	FEBRUARY		Pomeroy/	
JH	7, 8	Orthopedics and Sports Medicine in Family Practice	Bargren	(P)
	TBA	Hospital Budgeting		(A)
	MARCH			
JH	14, 15	Tacoma Academy of Internal Medicine	Ames	(P)
JH	16	Day of Pediatrics/Poisoning	Scherz	(P)
	APRIL			
UPS	12, 13	Surgical Club	Martin	(P)
STH	TBA	Neurology	Overfield	(P)
	MAY			
	TBA	Common Office Procedures	Klatt	(P)
JH	23, 24	Cardiovascular Disease Review	Strait	(P)
	JUNE			
	TBA	TPN	Pelham	(P/A)
	TBA	Advanced Cardiac Life Support	Dunn	(P/A)

Dates are subject to change—Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and/or have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137



MAXWELL MYER WINTROBE

Maxwell Myer Wintrobe has received many honors recognizing his international contributions to the field of medicine and specifically to hematology. He is the author of over 400 journal articles and presented the leading textbook of clinical hematology originally in 1942 and subsequently published in many languages. He has co-edited "Harrison's Principles of Internal Medicine" and written full texts and treatises in his field of hematology as well as others. He has many honorary doctorate degrees recognizing his eminence as a student, teacher and lecturer in medicine. He continues his active work at the University of Utah Medical Center in Salt Lake City, Utah.

1984

Edwin C. Yoder

Honor Lecture

Guest Speaker

Maxwell M. Wintrobe, M.D.

Friday, November 16, 1984

St. Joseph Hospital and Health Care Center

PHYSICIAN LECTURES

10:00 A.M.	"Hematology Today"
12:15 P.M.	Complimentary Luncheon
1:15 P.M.	"The Blossoming of a Science" — Honor Lecture —

NURSING/PARAMEDICAL LECTURE

3:30 P.M.	"The Blood & Blood Disorders"

For tickets and further information, contact the Medical Director's Office, **591-6767**

Searching for Arsenic Exposure Pathways

By
Kim Lowry

The ASARCO smelter in Ruston, Washington, currently emits approximately 100 metric tons of arsenic into the atmosphere a year, according to Puget Sound Air Pollution Control Agency estimates.

Pierce County physicians may soon hear patients commenting on their participation in a two-year, $926,000 study to investigate how arsenic from the smelter enters the body and leads to the elevated levels of urinary arsenic found in some residents of north Tacoma and Vashon Island. Volunteer participants will have their urine and hair assessed for arsenic and may undergo a test for peripheral neuropathy.

A team of faculty from the University of Washington School of Public Health designed the study and began research this September in conjunction with the Federal Environmental Protection Agency, the Centers for Disease Control and the Washington Department of Ecology.

While the ultimate objective of all these agencies is to reduce the elevated levels of urinary arsenic found in residents living near the smelter, the first step must be to determine the actual pathways by which the arsenic travels from the smelter to the body.

The investigation, called the Ruston/Vashon/Exposure Pathways Study, includes collecting environmental samples, such as air, dust, soil, and garden produce, from the yards and households of volunteer participants in the survey. Investigators will correlate the amount of arsenic they find with levels in the urine and hair of study participants. Scientists will select 120 homes within a two-mile radius of the smelter for sampling.

In addition to taking the samples described, the study team will ask those surveyed to undergo a nerve sensitivity test to check for peripheral neuropathy, which has been correlated with occupational exposure to arsenic. All participants will be reassured that while the arsenic contamination in the study area does not pose an immediate health concern, their cooperation will assist government agencies to determine what clean-up measures can reduce urinary arsenic levels.

The ASARCO smelter began operation as a lead smelter in 1890. Extensive reconstruction in 1912 converted the plant into a copper smelter which currently specializes in the smelting of copper ores rich in arsenic and other impurities. In fact, it is the only smelter plant in the United States that produces and markets arsenic trioxide and metallic arsenic.

During the early 1970's, the Washington Department of Social and Health Services noted high arsenic levels in urine collected from children living in the Ruston area. While the level in unexposed children is less than 10 micrograms/liter of urine, the most recent data from a Department of Social and Health Services study shows an average value of 36 micrograms/liter for the 22 Ruston children sampled. Arsenic levels in this study ranged from a low of 10 micrograms/liter to a high of 116 micrograms/liter.

The resultant concern about possible environmental contamination and adverse health effects from arsenic exposure has led to approximately 20 studies conducted in the north Tacoma, Ruston, and Vashon Island areas.

The findings showed elevated arsenic levels in the environment, i.e., in air, soil and road dust, and in the biological sphere—in human urine. However, since most of these studies were carried out independently and lacked uniform sampling and analysis, comparisons among them are unreliable. This has made it difficult to recommend corrective action for contaminated areas.

In March, 1982, the Commencement Bay Superfund Air Work Group, composed of representatives from local, state, and federal agencies, concluded that arsenic exposure from the ASARCO smelter emissions posed a potential health risk to people in the greater Tacoma region. The group urged that a new investigation, the present Exposure Pathways Study, be conducted to bring the area affected by smelter emissions under the Commencement Bay Nearshore-Tide Flats Superfund agreement. This agreement, between the state Department of Ecology and the Federal Environmental Protection Agency, represents a cooperative effort to evaluate and, where indicated, to clean up chemical contamination in the area of Commencement Bay.

The Pathways Study protocol calls for extensive sampling during the year-long collection of data. Between January, 1985 and 1986, investigators will visit each of the 120 homes four times. During each visit they will take the following kinds of samples:

Air samples: air within the home, using a small pump and filter system over a 24-hour period; outdoor air, employing a dichotomous sampler for the same period; and air in the breathing zone. (Subjects will be asked to wear a personal air monitor for a day during waking hours.)

Dust samples: vacuum cleaner contents; dust from a shelf or refrigerator top, wiped up with a piece of gauze; dust from a bucket fitted with a filter in its bottom, which will be left to collect dust for three months following each visit; handwash samples, to show how much dust the hands collect, a pathway of potential importance for toddlers; and road-dust.

Soil samples: tilled and untilled earth from the grounds surrounding the house.

Water samples: water from wells and cisterns.

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Pertussis Case Count Continuing to Rise

Report by Bud Nicola, MD, Director of Health, Tacoma-Pierce County Health Department

Since May of 1984 the case count for pertussis continues to rise in both Pierce and King Counties. Pierce County now has 14 cases with an additional two suspects: 29% 4 months of age and below, 36% over age 17, and the remaining 36% evenly distributed between ages 5 and 17. 79% of cases have incomplete immunization status or inadequate documentation of immunization.

Seattle-King County Health Department reports 88 cases during the same time period: 20% over 20 years of age, 25% under one year with the largest portion of infants under two months, and the remaining 55% evenly distributed between the ages 2 and 19. Most cases involved inadequate immunization histories, although a few school age children report full immunization.

General use of pertussis vaccine since the early 1940s has decreased the annual incidence of pertussis in the USA to 2,300 cases and ten fatalities. In Washington State, 856 pertussis deaths occurred between 1920 and 1942 and declined to 91 between 1942 and 1982. As recently as 1977, 71 cases and two deaths occurred and in 1981, 58 cases and one death were reported.

Case Identification and Diagnosis

The case definition includes patients with: 1) symptoms and positive culture and/or positive florescent antibody (FA); 2) symptoms and known contact with a positive case; 3) positive culture or FA.

Centers for Disease Control warn that accurate data does not exist since many cases go unrecognized and testing is not uniformly available. Most cases occur in children under 12 months and 50 percent under six months of age. Older children and adults serve as reservoirs of infection where the disease presents as bronchitis or severe upper respiratory infection. Pertussis may not be diagnosed because classic signs, especially the inspiratory "whoop," are absent.

The initial "catarrhal" stage of the disease, beginning with symptoms of a common cold and worsening cough, lasting one-two weeks, is the most infectious stage and usually goes unsuspected unless there is an outbreak or known contact with a case.

The paroxysmal stage is identified as the cough comes in explosive bursts followed by the characteristic inspiratory "whoop" or "crowing." This may be accompanied by cyanosis, vomiting, prolonged inspiration and apnea. The cough frequently persists one-two months. As stated, the "whoop" may be absent, particularly in infants under six months, in older persons and in **those partially protected by vaccine.**

Diagnosis is based on recovery of B. pertussis from either florescent antibody FA positive nasopharyngeal smear or a culture. The organism can be recovered from the posterior nasopharnyx with a special calcium alginate swab left in place 15-30 seconds when the specimen is collected. Charcoal transport media and Bordet-Gengou Agar plates are re-

Protocol for Pertussis Specimen Collection

B. Pertussis — *Procedures for collecting and submitting specimens for laboratory examination—Parallel Direct FA and Charcoal Agar Testing*

1. Specimens will be accepted only from patients whose physicians suspect pertussis on the basis of symptomatology.
2. All specimens must be collected from the nasopharynx. To obtain specimen, immobilize patient's head and gently pass swab through nostril into nasopharynx. Care must be taken to avoid touching the sides of the nasal passage. When the swab meets resistance, it is gently rotated. Throat swabs are not satisfactory.
3. The swab should then be aseptically streaked on the Charcoal Transport Media (CTM) and the wire cut with scissors or wire cutters so that the cap can be screwed on. **Do not bend the wire into the CTM tube** for this procedure might introduce skin flora into the CTM. Label the CTM tube with the date and the patient's name.
4. Collect another specimen from the nasopharynx. This swab should be streaked over an area the size of a quarter on the surface of a microscope slide. Slides should be submitted in duplicate.
5. The slides should be allowed to dry in the air. **Do not** heat-fix.
6. The specimens should be accompanied by two Public Health Laboratory Request Forms. One of these is for the direct FA slides and the other is for the culture.
7. Mail the slides separately in a cardboard slide holder enclosed in an envelope.
8. Place CTM tube in double mailing container and mail immediately to the laboratory.
9. If you have any questions concerning these procedures, Contact Chuck Brown, (1-206-464-6528) at the State Health Laboratory.

Continued

quired for pertussis culturing. Media is available at Tacoma-Pierce County Health Department, Communicable Disease Section, phone 591-6410. Those with chronic paroxysmal cough and low grade or no fever should be reported to the Health Department.

Recovery of the organism may be expected in 70-90 percent of cases in the "catarrhal" stage and 50 percent in the first two weeks of the paroxysmal stage. This may be reduced if antibiotics have been used. Documenting the presence of the disease is of great value in epidemiologic follow-up and the Health Department staff will be happy to assist you in identification and follow-up of suspected cases.

Procedure for collecting and submitting specimens should be strictly followed. The protocol for pertussis specimen collection is available at the Tacoma-Pierce County Health Department. Florescent antibody sample kits have been distributed to most emergency rooms and turnaround time from the state health laboratory has been 24-hours.

Prophylaxis

Antimicrobial agents have no effect on the clinical course of pertussis when administered in the paroxysmal stage of the disease, but may limit the communiability of pertussis. The drug of choice is erythromycin (50 mg/kg per day for 7 to 10 days). The Center for Disease Control staff recommends that the patient be kept in respiratory isolation for 96 hours after the onset of therapy with erythromycin.

Chemoprophylaxis with erythromycin to prevent disease has yet to be fully estabilished, but at the present time we are recommending that all household and close contacts: 1) less than 1 year of age be given erythromycin prophylactically (50 mg/kg per day for 10 days), 2) less than 4 years of age and greater than 1 year of age be given erythromycin if their immunizations are not up-to-date (at the personal physician's option), 3) older children as a general rule not be given erythromycin except on a case-by-case basis as determined by their personal physician.

Prophylaxis should be started within two to three days of exposure, after this time it may be more appropriate to wait and test those who are symptomatic.

At the present time, we are not recommending routine school exclusion for asymptomatic contacts at grade or high school level, but are recommending exclusion for symptomatic contacts.

Immunizations

Active immunization with pertussis vaccine is the only effective method of control. Because of the current outbreak situation, it would be appropriate to start the initial dose of DPT at 6 weeks of age followed by two additional doses at 10 and 14 weeks.

Although concern about side effects has made the use of pertussis vaccine controversial, three doses of vaccine has been estimated to be 80 to 90% effective in preventing clinical illness. Adverse reactions range from minor local discomfort to serious neurologic illness. Encephalopathy, the pertussis reaction which has caused most concern, has been estimated to occur once for every 110,000 to 168,000 injections. Estimates for permanent brain damage include once for every 310,000 to 405,000 injections.

Continued on page 17

AUXILIARY NEWS

Medical Society and Auxiliary Spend Evening at China Exhibit

Two busloads of physicians, spouses and friends left Humana Hospital (on time!), July 31, for an evening at the China Exhibit to view 7,000 years of discovery. About the same time as the buses arrived, close to 20 or more of the group arrived at the Pacific Science

Center, Seattle, where the exhibit was held. A Chinese buffet, first on the agenda, was hungrily devoured by all.

Everyone toured the exhibit at a leisurely pace. The working displays were very popular spots to stop; papermaking, embroidering, ceramics—to mention a few. Those who went found many items of interest. Thanks to Sharon Lawson for making the arrangements. Super Job!

Mini-Confluence Oct. 30–31

There will be a mini confluence in Las Vegas, October 30–31. Any Auxiliary member can and is encouraged to attend. Medical Auxiliary News has further information.

Don't Miss It: Fashion Show Oct. 19

Have you been wondering what the latest fashion is for holiday wear, sporting events, career wear? Wonder no more! Find out at the Pierce County Medical Auxiliary Fashion Show, Oct. 19, at the Sheraton Hotel, Tacoma. Susie Duffy and Marny Weber are co-chairpersons for the event. Adding to the excitement will be a showing of clothes from the Fashion Mart by Andrews Apparel. There will be an 11:00 A.M. social hour followed by lunch at 11:45 A.M. Cost for the event is $15.00, including the tip. Guests are welcome. Come and join us for this exciting event. Send your check by October 12 to Grace Kanda, 1716 Academy St., Sumner, WA 98390.

Thinking about Volunteering, Getting Involved?

You say you would like to get involved with the auxiliary and its projects but feel unsure of the who, what, when, where, and how. Give Bev Law a call, 564-6515. She knows the questions to ask to help you figure out just where you can make a contribution to the auxiliary and the community. You will receive much more than you give. Call Today!

Help Fight Child Abuse

All auxiliary members are encouraged to participate in the new board approved Parent Support Program. There are several different kinds of volunteers needed. Come join the fight against child abuse. Call Sharon Ann Lawson, 565-6674.

Auxiliary News, continued on following page

Auxiliary News, continued from previous page

Holiday Sharing Cards Available Now

It's nearly time to think about sending Holiday greetings to friends. An AMA–ERF Holiday sharing card may be the way to remember others. A card is sent to every Medical Society member with an enclosed list of contributors. All the funds are payable to AMA–ERF and are sent to the medical school of your choice. Your donation is tax-deductible. The cards are available now for ordering. Catalogs of samples are here along with gift wrap and ribbon.

The cards are carefully selected and designed to appeal to individual needs. This year we are also offering a high quality, smartly designed new line of gift wrap, ribbons and ties. Forty to fifty percent of all profit will remain with the AMA to assist in funding for medical research and education. The greeting cards will be available at all our meetings and other times arranged throughout October.

This year we have designated the week of October 21-26 for displaying and merchandising the Holiday Sharing Cards at Tacoma General, St. Joseph, Doctors, Lakewood General and Good Samaritan Hospitals. To make this week a success we need help in displaying and receiving orders. Any amount of volunteer time at any of the listed hospitals would be appreciated. You can help by contacting Tina Sobba, 565-2958, or Nikki Crowley, 922-8283.

Pierce County has been number one in donations in Washington for many years. Keep up the good work. Watch for your letter coming soon with all the information you need to make 1984 a banner year for AMA–ERF.

Membership Booklets

Those of you who have received your Medical Auxiliary Membership Booklet are asked to check your address and phone number. If it isn't correct, please call Marilyn Bodily, 565-7224. If you haven't received it, check with Marilyn.

Speakers Bureau's Files Being Updated

Kathy Stark, chairperson for the Speakers Bureau, tells us the committee is in the process of updating the Bureau's files. New questionnaires have been sent to all physicians. Approximately 100 physicians have responded so far with information. The date is computerized for easy accessibility.

In September a brochure with information concerning the Bureau and its potential use will be sent to all schools and special interest groups. We are hoping that more physicians will fill out the questionnaires and return them. Auxiliary volunteers are needed to help Kathy, 565-7411. If you have some time to help her, it would be appreciated.

HOSPITAL NEWS

St. Joseph

Diabetic Unit Opens

Since July 1 patients with diabetes or other endocrine disorders have been receiving special care at St. Joseph Hospital's diabetic unit. The specialized unit has four to six patients a day.

"Previously, diabetic patients had been scattered throughout the hospital," says Delores Reagan, RN, CNA, assistant director of nursing service. "We recognize that not all of the diabetics can be in the diabetic unit due to their specific condition, but those admitted to the unit will receive very comprehensive diabetes education and health care."

According to Ms. Reagan, in the special care diabetic unit the admitting physician directs the care, selects portions of the teaching plan for the patient and may participate in the patient care conference. An endocrinology consultation is available at the physician's request.

Key organizers for the unit were Sonja Williams, nurse manager of the unit, Delores Reagan and Cheryl Keely, nurse educator.

Registered nurses and licensed practical nurses in the department have taken the first of two comprehensive courses in caring for diabetic patients developed by Cheryl Keely, RN. The second course will be taken early this month.

Other health team members include a nurse educator, dietician, social worker, pharmacist and a representative from the pastoral care department.

Federal Way Hospital Administrator Announced

Craig L. Hendrickson, 38, former Executive Director at Allenmore Community Hospital in Tacoma and currently the Administrator/President of Tempe St. Luke's Hospital, Tempe, Arizona, has been appointed to head Federal Way's new St. Francis Community Hospital, according to Faye Clerget, who chairs the hospital's board of trustees.

"We selected Mr. Hendrickson because of his experience in operating a hospital of similar size (Tempe St. Luke's is a 110-bed not-for-profit general acute care hospital) and which is related to a larger Arizona hospital (similar to the relationship between St. Joseph, Tacoma, and St. Francis, Federal Way)," Mrs. Clerget said. "His administrative record there has been impeccable and we feel fortunate in obtaining his services," she said.

Mr. Hendrickson was chief executive officer at the 155-bed Allenmore (Humana) Hospital, Tacoma, from 1979 –1982.

Mr. Hendrickson received a master of science degree in health care administration from the University of California at Irvine in 1977.

Continued on page 17

Hospital News, continued from previous page

He holds memberships in the American College of Hospital Administrators and the Arizona Hospital Association, and is active in such community groups as Rotary International, Tempe Chamber of Commerce, Tempe Diplomats, Tempe YMCA board of directors, and the University of California Alumni Association board of directors.

Mr. Hendrickson and his wife, Linda, have three children, Justin, 10, Bret, age 7, and Paula, age 3. The Hendricksons plan to make their home in the Federal Way area some time in August at which time he officially assumes his administrative duties at St. Francis.

Pertussis Case Count Continuing to Rise, continued from page 13

Several precautions about pertussis vaccine are important to recognize. The vaccine should **not** be administered to adults or to children over the age of seven. Children with evolving neurological disorders including brain injuries, seizures, or a history of meningitis or encephalitis should **not** receive pertussis vaccine. The occurrence of a severe adverse reaction (e.g., vasomotor collapse, shock, persistent screaming of greater than 3 hours duration, fever above 105°F, convulsions, or bulging fontanels) is reason to withhold subsequent pertussis vaccine and administer DT for further scheduled doses. Systemic allergic reactions, thrombocytopenia, or hemolytic anemia which follow vaccination are contraindications to further use of DPT for persons experiencing these events. Also, pertussis vaccination should be deferred for persons who have severe febrile illnesses or immunosuppressive therapy of more than three weeks' duration. Pertussis-only vaccine is available from the Health Department for special patients' needs.

The Benefits of Immunization far exceed the risks for normal, healthy children. Recent experience in England and in Japan, where pertussis vaccine use declined because of controversy related to side effects, has shown that the incidence of this sometimes life-threatening illness can quickly rise to epidemic proportions. We urge physicians in Pierce County to appropriately immunize their patients against pertussis.■

CLASSIFIED

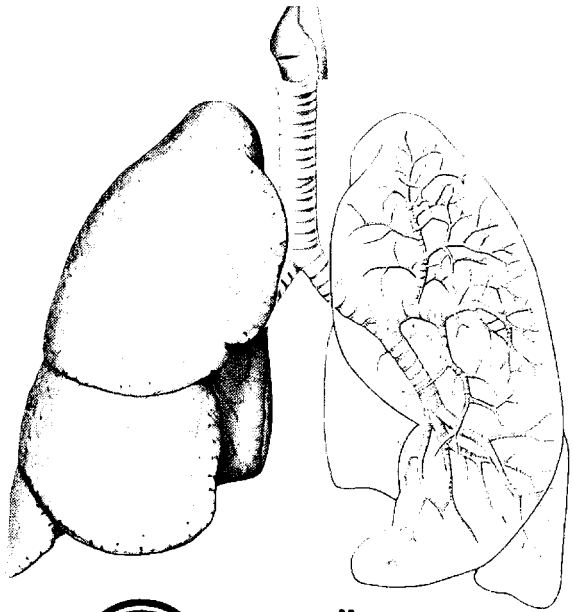
Fully Equipped Medical Office—available in Lakewood. Furnishings like new; reasonable rent; one block to hospital. Purchase equipment only. Contact P.O. Box 111737, Tacoma, WA 98411-1737.

Northeast Tacoma Professional Center—Great Location above Brown's Point. New professional office space. Two blocks from Jr. High. Energy efficient. Full basement for mechanical and storage. Interiors to suit. Super competitive leasing terms. This great community needs more coverage. Dennis/-Jean (206) 272-2713.

Space for Lease—in well established professional building. North 27th and Adams. 759-6800.

View Home: Gig Harbor—Now $120,000 by owner. I've slashed $16,000 off the price on this 2,800 sq. ft., 3 bedroom home with many amenities. Must sell by summer. Call George: 1-851-5248.

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary: Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*) *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of neonates whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy – *Pregnancy Category B* – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers – Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal: symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia) and, frequently, fever have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information to the physician.

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

106182R1

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Caguas, Puerto Rico 00630

8-1-84

MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

John C. Hill, MD, *Cardiology*: Born in Portland, Oregon, 12/31/37; medical school, Univ. of Oregon Medical School, Portland, Oregon, 1964; internship, Fitzsimons General Hospital, Denver, CO, 7/64–6/65; residency, Madigan General Hospital, Tacoma, Washington, 9/65–8/68; fellowship, cardiology letterman General Hospital, San Francisco, CA, 9/68–7/70. Washington State License, 8/66. Dr. Hill is currently practicing at 1624 South "I" Street, Tacoma, WA.

Larry D. Stonesifer, MD, *Internal Medicine and Endocrinology*: Born in Fayetteville, AR, 3/2/50; medical school, Univ. of Arkansas, Little Rock, AR; internship, Univ. of Arkansas, Little Rock, AR, 7/76–6/77; residency, Univ. of Arkansas, Little Rock, AR, 7/77–6/79; fellowship, Univ. of Arkansas, Little Rock, AR, 7/79–6/81. Washington License, pending. Dr. Stonesifer is currently practicing at 314 South "K" Street, Tacoma, WA.

Estelle Ikuko Yamaki, MD, *Obstetrics–Gynecology*: Born in Honolulu, Hawaii, 5/30/54; medical school, Albany Medical College, May, 1980; internship, Hartford Hospital, Hartford, CT, 7/81–6/84. Washington State License, pending. Dr. Yamaki will begin practicing at 728 South 320th, Federal Way.

Amy Yu, MD, *Oncology & Hematology*: Born in Taiwan, 3/4/54; medical school, Loyola Univ., 6/79; internship, Northwestern Univ. Medical Center, 7/79–6/80; residency, Northwest Univ. Medical Center, Chicago, IL, 7/80–6/82; fellowship, oncology, Univ. of Washington, Seattle, WA, 7/82–6/84. Washington State License 7/82.

The following information is
presented by Pierce County Medical Bureau.

OUR PREFERRED PROVIDER PLAN

Bruce D. Buchanan, M.D.
Chairman, Board of Trustees,
Pierce County Medical Bureau

One year ago, the Bureau's Board of Trustees appointed an Alternative Delivery System Committee, chaired by Ben Blackett, M.D., in response to the increasing pressure of competition in our marketplace and the consequent concern of a significant number of our providers that their patients might be forced to seek care elsewhere. The committee recommended that the Bureau offer a Preferred Provider Plan, in addition to its standard coverage, to give the consumer a choice of product.

I am pleased to be able to report that our Preferred Provider Plan will be operational in January of 1985; in fact, it has already been selected by a large local corporation. This makes us the first health care contractor in Washington to establish a Preferred Provider Plan, thanks to the strong support of our member physicians.

Needless to say, a great deal of time and effort has been spent in preparing this "managed health care" program. A separate committee of the Board of Trustees was formed under the chairmanship of Robert Whitney, M.D., to develop a "PPP" philosophy and design the plan. Concurrently, Karen Kiehn joined the Pierce County Medical Bureau staff as Manager, Alternate Delivery Systems to coordinate the implementation of the PPP and provide support and guidance to the committee.

I would like to commend the members of the Design Committee for their concentration and efficiency: Drs. Whitney, Doelle, Farber, Ferguson, Klatt, Lazar, McKelvey, Vitikainen and Virak.

The design of the plan is excellent. But that does not mean that our product is inflexible. It is understood that it will be modified and perfected as the future dictates.

Our Preferred Provider Plan will give people who are concerned about the high cost of health care a real choice. And, it will keep our patients from leaving our offices in favor of HMO's. Naturally, this means our new product must be competitively priced.

Essential to the success of the new plan is the willingness of providers, patients and the Bureau to share in the responsibility of containing costs. For the patient, this means mandatory second surgical opinions and mandatory outpatient surgery for certain conditions as well as preadmission certification. There is additional out-of-pocket expense for visits to the emergency room. In order to receive full benefits, patients must use preferred physicians, hospitals, pharmacies and other providers.

Preferred providers must adhere to strict standards of cost-effectiveness and careful utilization, which will be subject to continuing review. Preferred participants also agree to reduced reimbursement, with the knowledge that the savings is passed directly to the consumer in the form of lower monthly rates for coverage under the Preferred Provider Plan.

Although the discount by preferred physicians will be standard for this first year, I personally feel that, in the future, the Preferred Provider system must accept a diversity in discounts. To be explicit, procedure-oriented physicians should contribute a greater savings than those who offer the cognitive services in family practice, pediatrics and internal medicine.

I encourage your participation as preferred providers. And, as always, I welcome your comments or questions on this editorial or any other issues pertaining to Pierce County Medical Bureau.

Bruce D. Buchanan, M.D.
Chairman, Board of Trustees, Pierce County Medical Bureau

Paid for by Pierce County Medical Bureau

Searching for Arsenic Exposure Pathways, continued from page 11

Biological samples: garden fruits and vegetables, when available; human hair (arsenic binds to the sulfhydral groups in the hair shaft); and human urine, collected from adults and children for two days following each visit.

In addition to the sampling, investigators will administer questionnaires to study participants, asking about variables that might influence exposure levels, such as gardening habits, ratio of time spent indoors and outdoors, and length of residency in area.

Those who volunteer for nerve sensitivity tests, using thermal plate and Optacon testers, will be assured that so far there are no clinical reports of peripheral neuropathy in the community. Investigators are administering this test because several studies conducted elsewhere reported individuals whose peripheral neuropathy correlated with occupational exposure to arsenic.

No one has yet studied this effect in the general community. The results of nerve sensitivity tests in the north Tacoma area should indicate whether a community study would be worthwhile.

The smelter plant is scheduled for partial closure in June, 1985. At this point very little is known about the closure schedule and procedure. It is known that arsenic will continue to be produced; however, the exact process and pollution control that will be used are uncertain. In light of this, some have questioned why the study is needed now. Because arsenic has accumulated in the environment around the smelter and because ASARCO will continue to produce arsenic on its grounds, the Pathways Study remains pertinent and will help environmental and health agencies formulate clean-up and protective measures. Furthermore, data collected before and after partial closure of the plant may help clarify the role of airborne arsenic as a contributor to urinary arsenic.

After the year of data collection, investigators will use a statistical model called path analysis to determine which variables, such as soil and air, are most influencing urinary arsenic levels, important information to the agencies responsible for clean-up measures. Sample and data analysis with the writing of the final report will be concluded in June, 1986.

In an effort to keep the community informed, during the two-year project investigators will make presentations describing their work to public meetings, to schools which include students participating in the study, and to news media.

A physician from the study will be available to answer participants' questions. Investigators will also provide personal data from the study if a participant requests it. Should participants then question a family doctor about the significance of arsenic levels in their urine or hair, investigators will help the physician interpret the data. The University of Washington study team welcomes questions and suggestions.

Investigators can be contacted through Kim Lowry, the study manager at the phone number: (206) 467-4267. ■

Kim Lowry is present Project Manager, University of Washington School of Public Health

From "American Medical News," August 24/31, 1984, p.22.

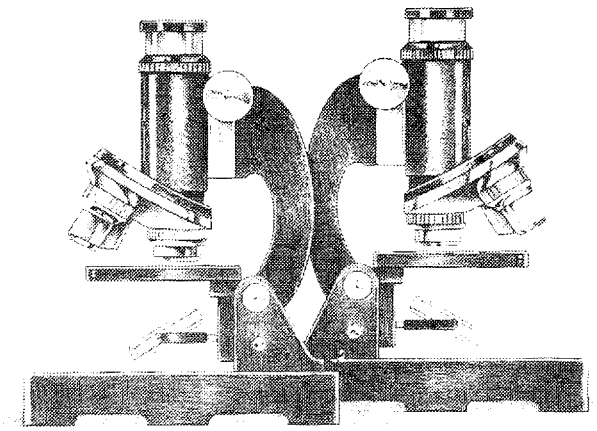
AMA Claim Form Updated

The AMA claim form has been updated and revised. The new form, which incorporates changes that were requested by the Health Care Financing Administration (HCFA), has been available since June 1. Using the old form after Dec. 1 could delay reimbursement. HCFA has approved the new form for Medicare and Medicaid. It is now the most widely used and accepted claim form in the United States. More than 30 Blue Shield plans use the AMA form. The Health Insurance Assn. of America also recommends it to 300 member companies. To receive an information packet, write to the AMA Dept. of Health Care Financing and Organization, AMA headquarters, Chicago.

Computer Ownership by Physicians Growing

Computer ownership by physicians will grow, according to a survey commissioned by the AMA Dept. of Advertising Communications. The survey of 1,000 physicians showed that 34% of the 372 respondents have access to a computer. Of these, 30% are computer owners, and the remainder either rent a computer or use a service agency. The 66% who do not have a computer included 16% who said they planned to buy or lease one, and 45% who said they did not plan to do so.

BLUE CROSS COVERAGE IS CHANGING IN TWO IMPORTANT WAYS.



In response to employer demand for cost containment programs, Blue Cross of Washington and Alaska is now implementing the Second Surgical Opinion Program (SSOP) and the Outpatient Surgery Program (OSP).

Mandatory Second Opinions. With SSOP, Blue Cross requires its subcribers seek a second surgical opinion after surgery is recommended by a physician, though the second opinion need not be confirming.

SSOP applies to elective, non-emergency procedures only. The Plan pays 100% of UCR for all required second opinions.

Outpatient Surgery. For groups that have the OSP, Blue Cross requries that certain elective procedures be performed on an outpatient basis or be precertified for inpatient.

Outpatient Settings. Outpatient surgery may be performed in a doctor's office, free-standing surgical center, or hospital outpatient location.

Benefit Requirement. SSOP and OSP requirements must be followed or the subscriber will be financially responsible for the primary surgeon's fee.

For a brochure and complete list of SSOP/OSP forms and procedures, contact Blue Cross Customer Service at P.O. Box 327, Seattle, Washington 98111.

Blue Cross
of Washington and Alaska

DR. RANDY VALENTINE, D.V.M.:

OTHER BANKS BARKED. NORTH PACIFIC BIT.

After nearly seven years of operating out of rented buildings, The Animal Emergency Clinic decided it was time to build a building designed to their very specific needs.

They looked at three banks.

Then the clinic group went to a specialist: North Pacific Bank, The Business Bank. North Pacific financed the 2,500 sq. ft. clinic at 56th and Durango.

"It's the first clinic in the state designed and built for emergency purposes," said Dr. Randy Valentine, current chairman. "It's a trauma center, open when other veterinary hospitals are closed—weekdays from 6:00 p.m. to 8:00 a.m., noon Saturdays to 8:00 a.m. Mondays and all holidays."

"The clinic provides crisis doctoring and full time emergency medicine much the same as the Emergency section of a regular hospital. There's a veterinarian on the premises with trained assistants throughout the night. Animals are never left alone."

"There are 20 partners involved in the ownership of the building. To get 20 veterinarians to agree on anything is a miracle. But we agreed unanimously to go with North Pacific."

Why?

"They gave us the best proposal, seemed most interested in our business, were close to our new location and we can see the value in dealing with a specialist, of course."

If your pet needs an emergency specialist, call 474-0791.

If your business needs an emergency specialist, call 472-3333.

NORTH PACIFIC BANK
THE BUSINESS BANK

Member FDIC

MEDICAL SOCIETY OF PIERCE COUNTY
705 South 9th, Suite 203
Tacoma, Washington 98405
ADDRESS CORRECTION REQUESTED

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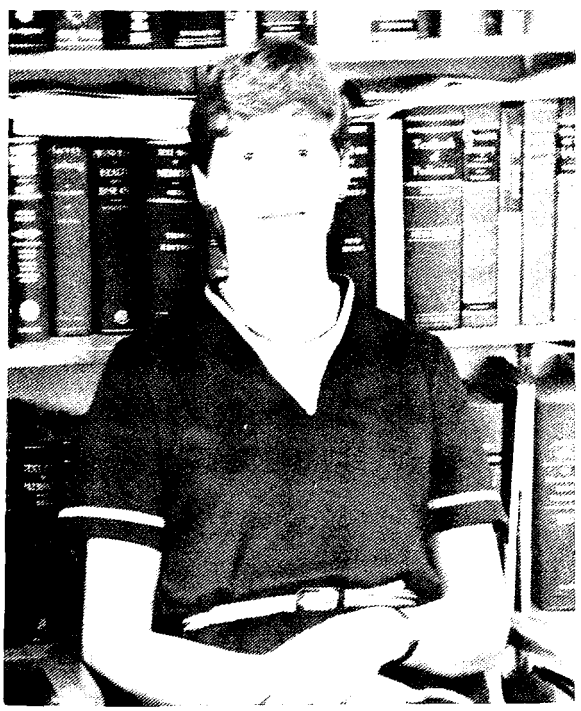
The Bulletin
MEDICAL SOCIETY OF PIERCE COUNTY

November, 1984



Women in Medicine, See Page 14

The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Cover Photo: Women Physicians in Pierce County Upper left, Dr. Eileen Toth; Upper right, Dr. Shirley Deem, Lower left, Dr. Rosemary Crawford, Lower right, Dr. Cynthia Wilson

CHANGING YOUR ADDRESS? HAVE A NEW ADDRESS?

Please fill out this **change of address** card and return to:

Medical Society of Pierce County
705 S. 9th
Tacoma, WA 98405

NAME _____

OLD ADDRESS _____

_____ PHONE _____

NEW ADDRESS _____

_____ PHONE _____

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The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Cover Photo: Women Physicians in Pierce County. Upper left, Dr. Eileen Toth; Upper right, Dr. Shirley Deem; Lower left, Dr. Rosemary Crawford; Lower right, Dr. Cynthia Wilson

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin*. *The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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President's Page

A Review: 1984 Washington State Medical Association Convention

I would be remiss if, in reviewing highlights of the recent state medical convention, I did not first extend my commendation to Pierce County representatives of the House of Delegates, to our AMA delegate and alternate delegate, Pierce County Medical Society's executive director and all of my colleagues who represented our concerns at the conclave. They were diligent, well informed, vocal and tenacious in their involvement in various aspects of the recent convention, especially in the House of Delegates and in Reference Committee B, chaired by our own Dr. Richard Hawkins.

The convention itself was one I would not have missed. Among major speakers was U.S. Representative Richard A. Gephardt (D-Missouri) who discussed not only the past, but possible future congressional initiatives to control health care costs. Rep. Gephardt is, as many of you know, co-author of the Medical Solvency-Health Care Finance and Reform Act of 1984 (popularly referred to as the Kennedy-Gephardt Bill), a bill to which I have referred in previous columns.

In his presentation, Congressman Gephardt acknowledged, in detail, many accomplishments in the world of medicine: The increase in life expectancy, improved quality of life, reduction in infant mortality and others. He noted, paradoxically, that some of the successes of medicine have fostered some of the problems the profession faces today. In his words, "They are, indeed, complex problems."

Among them: Health care costs in 1982 were 10.5% of the gross national product (by comparison, housing represented 11.5% and food, 12.4%). In addition, he indicated that some 20 million Americans are without health care coverage and that, by 1985, projected cost for the Medicare Program is $256 billion.

The reasons? In the Congressman's eyes, such increased Medicare costs can be attributed to four factors:

1) Volume—Some 30 million persons are now in the program.

2) Technology—"New concepts, new equipment."

3) "The aging factor"—At present, 13.2% of our population are over the age of 65. It is projected that this percentage will increase substantially in the next decade.

4) Malpractice—In excess of 60% of malpractice settlements go to persons other than the patients who file the suits.

In order to control spiralling medical costs, Representative Gephardt offered three options: 1) Raise taxes; 2) cut benefits; 3) make the system more efficient. At no surprise to his audience, Congressman Gephardt concluded that the third alternative—increased efficiency—is by far the best alternative on which to focus, although the other avenues deserve pursuit.

The speaker urged physicians to provide positive input with regard to solutions to the problem, and not merely register complaints. "If we take the path of least resistance and go the way of other industrialized nations, we will pay a heavy, heavy price," he concluded.

Another convention speaker worthy of note was Stanley Wohl, MD, author of the book, *The Medical Industrial Complex,* who predicted that, within the next 25 years, the majority of hospital beds will be corporate-owned. Indeed, at this writing, for-profit corporations own approximately 66% of the chronic beds in the U.S. and 35% of the acute beds. Dr. Wohl explained this trend by stating that the prospective payment system favors a corporate influence: Corporations realize the potential profits in the health care industry.

One of the most heated debates at the convention took place in Reference Committee B deliberations, chaired, as previously noted, by Dr. Richard Hawkins. PRO/W, as you may know, signed a two-year contract with Medicare to serve as the reviewing agent in the state of Washington. That contract was signed the first day of the conference, after many months of negotiation.

Those opposing PRO/W were concerned with the lack of communication between the reviewer and the physician being reviewed. Some persons disputed the situation of physicians reviewing physicians thus, as they noted, pitting colleague against colleague.

And the subject of malpractice raised its head in a number of sessions at the convention. Washington State Senator, Phil Talmadge (D-34th District), a luncheon speaker, attempted to justify his committee's management of the Tort Reform Bill. Sen. Talmadge is chair of the Senate Judicial Committee. For the most part, his justifications fell on deaf ears.

Despite our displeasure at the Talmadge committee's action, our House of Delegates rejected a resolution calling for WSMA actively to pursue tort reform through the initiative process at this time, due to the immense projected cost and limited chances of success. However, it was noted in committee that the state of Florida passed a similar initiative on tort reform by assessing physicians statewide in order to bring the issue to the entire population of Florida.

Beyond all of this, cognitive vs. procedural reimbursement was the subject of several convention resolutions. Because of confusion with regard to specific recommendations, a resolution was passed calling for more specific recommendations to be prepared for the 1985 House of Delegates.

And, finally, the PACE Program, under the able leadership of our past president, Dr. Richard Ambur, is alive (in infancy) and rapidly maturing. The program's public relations coordinator is our former executive director, Thomas Curry. Any complaints, compliments or suggestions may be directed to Tom, I am told.(!)

As you may surmise, discussions regarding reducing the costs of medicine provided a thread upon which the 1984

President's Page, continued on page 8

LOCAL NEWS BRIEFS

Pierce County Physicians Elected to WSMA Leadership

The annual WSMA House of Delegates meeting in Seattle, Sept. 12-16, elected the following Pierce County physicians to roles of leadership positions:

Dr. Stanley W. Tuell, re-elected to serve a one-year term as WSMA Speaker of the House

Dr. Robert G. Scherz, elected to serve a one-year term as WSMA Trustee

Dr. Lloyd C. Elmer, elected to serve a two-year term as WSMA Trustee

Dr. David Hopkins, presently serves as WSMA's Delegate to AMA

Dr. Ralph Johnson, as WSMA's alternate Delegate to AMA

The society submitted five Resolutions for consideration before the House of Delegates as follows:

1) Payment of Dues: Be it resolved that the Washington State Medical Association pursue efforts to permit members a more flexible dues payment system. *Resolution adopted.*

2) Contracting: Be it resolved that the Washington State Medical Association establish a Contract and Evaluation and Negotiation Services Department to:
   a. Serve as a clearing house for information on contracting for physicians.
   b. Disseminate information on contracting to physicians.
   c. Provide an objective analysis of physician contracts

Resolution rejected.

3) Retired Physician—Loss of License: Be it resolved that the Washington State Medical Association actively supports the placement of retired physicians by the Department of Licensing on an "inactive" list rather than require them to surrender their license. *Resolution rejected.*

4) Smoking: Be it resolved that the Washington State Medical Association Legislative Committee and staff take an active and visible public position in opposition to smoking, and lobby coordination with county medical societies, volunteer health agencies and other concerned groups before the 1985 session of the Washington State Legislature. *Resolution amended.*

5) Protective Headgear—Equestrian Activities: Be it resolved that the Washington State Medical Association recommends that riding schools, horse shows and other events in which young persons participate with horses should require wearing of appropriate protective headgear during such activities. *Resolution adopted.*

Nominating Committee Selects Candidates for 1985

On October 10, the Nominating Committee met to select the leaders of the Medical Society for 1985. Dr. Duffy and members of the committee were pleased with the number of qualified and willing candidates. All of them have been active in the Society and medical community activities and are well abreast of the many issues facing organized medicine today.

The Nominating Committee's slate of nominees will be sent to all Medical Society members on November 1, 1984.

In accordance with the by-laws, nominations may be received by petition. The petition must state the nominee and the office for which he is being nominated; the petition must be accompanied by the nominee's written statement of consent to serve, if elected; the petition must bear the signature of at least five active or honorary members of the society.

The petition must be received in the Society's office by Nov. 6, 1984. Nominees will be published in the December issue of *The Bulletin*

Ballots will be mailed to all active and honorary members on November 19. They must be returned to the Society's office no later than Friday, Dec. 7, to be tabulated.

Election results will be announced at the December 11 Joint Medical Society-Auxiliary Dinner.

Joint Dinner Meeting Coming Up, December 11

Mark your calandars for the December 11 Joint Dinner Meeting. An unforgettable program is being planned. The meeting will be held at the Tacoma Sheraton beginning at 6:15 P.M.

Local News Briefs, continued on page 6

Washington Physicians Go On Record To Support AMA's Legal Challenge of Medicare Program Changes

Criticizing the impact the "Deficit Reduction Act" will have on the elderly, the Washington Medical Association went on record, September 25, in support of the AMA's legal challenge of the act.

WSMA President Dr. John M. Kennelly, Jr. said in a press release, September 25, a week after the AMA legal challenge of the act, that the "Deficit Reduction Act," passed by Congress in July, was highly unfair to the elderly and physicians, and unnecessarily pitted the elderly against physicians.

Because the law requires the Medicare program to publish lists of physicians who "participate," the WSMA has sent a bulletin to its members urging them to inform their senior patients how they will handle the medical bills.

"It is vital," said Dr. Kennelly, "that physicians communicate and cooperate with senior patients. The physician must be first, last and always, an advocate for his or her patient, doing what is best for that patient."

The American Association of Retired Persons (AARP) plans an extensive effort for the WSMA and county medical societies to work closely with elderly groups to explain costs and help the elderly who need assistance receiving necessary medical care.

The AMA lawsuit, filed in Indianapolis, Indiana, challenges certain provisions of the medicare fee freeze amendments that are part of the "Deficit Reduction of 1984." The act contains over 300 provisions to reduce federal spending. More than 60 of the provisions affect the Medicare and Medicaid programs.

The complaint filed by the AMA covers three basic points:

1) The freeze of physicians' charges for 15 months is unconstitutional since it violates the equal protection laws.
2) It effectively denies beneficiaries the right to select their own physician.
3) It interferes unlawfully in the rights of physicians to contract with Medicare beneficiaries.

The AMA's request for a temporary injunction to stay implementation of the October 1 deadline for physicians to make their "participating" or "non participating" decisions under Medicare was denied. But the ruling of U.S. Federal Judge Sara Evans Barker on the injunction, granted limited relief to those physicians who were members of the AMA and/or the Indiana State Medical Association who were unable to obtain the complete Medicare information requested from their carriers.

Judge Barker ruled that all physicians who had failed to receive, as of September 28, the complete Medicare information they had requested from their carriers could extend their decision-making time to October 15. The extension was applicable to both written and telephoned requests that had been made to carriers.

Remaining to be heard by Judge Barker are the fundamental constitutional issues that the AMA has raised in its lawsuit.

Local News Briefs, continued on page 7

Financial Support for Medical Students Dwindles

Chicago—More medical students and residents than ever before are in the medical education system, but they are receiving less financial aid, according to the 84th Annual Report on Medical Education in the United States. The report is published the *Journal of the American Medical Association.*

Although numbers continue to increase, the rate has slowed considerably. Total enrollment in U.S. medical schools rose by less than one percent in 1983–1984, and first year enrollment has been declining for the past three years, according to the report.

Fifty-two percent of the 1984 medical school graduates accepted residency positions in family practice, internal medicine or pediatrics programs. The number of residents has increased steadily, with a total of 72,397 participating in accredited programs in 1983.

At the same time, financial assistance to medical students from all sources declined by approximately six percent. (Figures for 1982–1983 show a decline since 1954.) Scholarship funds decreased eight percent; loan funds decreased four percent. The average education debt reported by senior students was nearly $24,000, and more than 13 percent of the graduating class in 1983 reported debts of at least $30,000. Residency programs are also threatened by the reimbursement system of the diagnostic-related groups. DRGs payment mechanisms may lead to a decrease in a major source of financial support

The profile of medical students is also changing; one in three new medical students is a woman, and approximately 16 percent are members of ethnic groups. Blacks make up a little more than five percent and Asians another five percent. Twenty-four percent of resident physicians are women; approximately five percent of the total are black.

More than 96 percent of entering medical students have completed four or more years of college study. Approximately 45 percent of them obtained college grade point averages of 3.6 or higher. There were 9.1 applications per person to medical schools for 1983–84, and one of every two applicants was accepted. All medical schools have a four-year curriculum, except the University of Minnesota, Duluth, which is the only remaining two-year basic science school.

The report also notes an increase in the number of U.S. citizens who are attending foreign medical schools. Most of these graduates seek to obtain medical education experience in U.S. hospitals. To do this, they must meet the criteria established by the Educational Commission for Foreign Medical Graduates. The report says that less than 20 percent of residents are graduates of foreign medical schools, and more than half of these are U.S. citizens. To subsequently enter medical practice in the United States, they must meet requirements for state licensure.

AMA News Release, Sept. 28, 1984

Pharmacy Alert

Doctors and pharmacists should be on the alert for calls coming in, particularly on the weekends, requesting changes in a prescription or a request for a refill from individuals who may not have legitimate prescriptions. Doctors should provide their clinics with a complete list of their patients as a backup for checking these calls. If a request for a refill comes in over the weekend, it is recommended that the refill be given for the week-end only with instructions for the caller to follow up with their doctor.

Local News Briefs, continued on page 8

A Review: 1984 WSMA Convention, continued from President's Page

WSMA convention was based. My personal opinion is that, if we do not reduce costs, the government will impose increasing restrictions requiring us to do so. The profession of medicine is in another crisis state in this regard.

But let us remind ourselves that we have been here before. And we have survived. Optimism—and an instinctive belief in the abilities of my colleagues—tells me we will succeed, once again. I still believe that we are affiliated with the strongest medical organization in the world.

—JPD

Local News Briefs continued from page 7

U.S. Department of Labor Recruiting Physicians

The U.S. Department of Labor is in the process of recruiting physicians to serve as examining physicians for second opinions and impartial medical examiners to resolve conflicts of medical opinion in Federal industrial injury claims. These claims are administered by the Federal Employees Compensation Act Program (FEC). The regional office for the northwest is Seattle.

If any member is interested write a letter and send a copy of your curriculum vitae to: *U.S. Department of Labor, Office of Workers Compensation Programs, Federal Office Bldg., Room 4010, 909 1st Ave., Seattle, WA 98147. Attention: Dr. Bruce D. Adam.*

Physicians Elected to Medical Society Membership

Congratulations are extended to the following provisional members who have been elected to membership into the Medical Society of Pierce County at the September Board of Trustees meeting:

Drs. John C. Coombs, Samuel J. Insalaco, David R. Munoz, Paul Seward, Rebecca Sullivan.

Tel-Med Pledge Cards Still Being Accepted

Tel-Med pledge cards are still being accepted if you happened to misplace yours. To date nearly $4,400 has been raised by physician contributions. Put your name on the list.

MD Dissatisfaction is Predicted

Physicians will be less satisfied with their practices, health care costs will continue to rise, and Congress will limit malpractice awards by 1990, predicted a majority of respondents to an eight-month survey sponsored by the accounting firm of Arthur Andersen & Co. and the American College of Hospital Administrators (ACHA).

The Study, "Health Care in the 1990s: Trends and Strategies," is based on questionnaires sent to 1,000 health care experts. It represents a consensus opinion of changes that will occur over the next 10 years.

Six panels, or groups, were sent questionnaires: hospital leaders, physicians, other providers, legislators/regulators, suppliers, and payers.

Stuart Wesbury Jr., PhD, president of the ACHA, acknowledged that "there was no big surprise" in the study's results. "Most of the movements are already in place," he said.

Arthur Andersen claims that the results represent a consensus because of the way the survey was done. The results from a first questionnaire were sent to all respondents to ask them if they agreed with the answers their peers had given. In many cases, a respondent who was "on the fence" changed his answer to that of the majority.

The following are the tabulations from the second round of questionnaires:

Costs

- The panelists predicted that health care costs would consume 12% of the gross national product by 1990.
- Most of the groups said the main way to lower the cost of health care was to emphasize alternative delivery systems such as health maintenance organizations (HMOs). Physicians, however, advocated increasing patient deductibles and coinsurance as the best way to limit the rise of health care spending.

Quality and Access

- Competition among providers will lower the quality of care, 83% of the physicians thought. Only 19% of the payers agreed.
- Uninsured patients will experience a significant decline in quality of care, 87% of the panelists said.
- Ninety-eight percent of the respondents agreed that a minimum level of care was the right of all Americans. Only 12%, however, thought everyone was entitled to the same level of care.
- Not-for-profit hospitals provide the highest quality of care, more than 80% of the respondents said.

Malpractice

- Eighty percent of the respondents think that Congress will act by 1990 to limit malpractice awards.

Medicare

- Ninety-nine percent of the respondents projected a significant increase in Medicare premiums, deductibles, and coinsurance. They also predicted that Medicare would enact a means test based on income (89%), that the qualifying age for

Discussion on MD Dissatisfaction continued on page 21

College of Medical Education
Continuing Education Programs Scheduled for 1984-85

(Programming is subject to change—individual notices will be sent preceding each program.)

Phone: 627-7137

(P) = Physician **(A)** = Allied Health

Location	Date	Program	Coordinator	
	OCTOBER			
	10, 12, 17, 19, 26	Electrocardiography	Tac Gen	(P)
STJ	9, 16, 23, 30	Nursing Pharmacology	Pelham	(A)
STJ	11	Marketing & Persuasion Skills for Nurses	Vipperman	(A)
STJ	18, 25, Nov. 1	Chemotherapy	Chemo.	(A)
STJ	19	Right Brain/Left Brain—Increased Potential	McDonald	(P/A)
JH	24, 31	Writing on the Job	Dumond	(A)
STJ	18	Discharge Planning	Johnson	(A)
JH	24, 25	Practicle Solutions for Common Office Problems	Foss	(P)
JH	2, 9, 16, 23	Money Management	Jackman	(P)
	NOVEMBER			
SH	1	Marketing—Medical Practice	P S Hosp	(P)
JH	2	2nd Annual Cancer Education	Katterhagen	(P/A)
JH	14	Ostomies: Let's Learn About Them	Klatt/Chong	(P/A)
JH	16	Geriatrics	Munoz	(P/A)
STJ	15, 16	Survival Skills for Nurses	Dean	(A)
EX INN	TBA	Ward Secretary	Absher	(A)
STJ	29	Ethical Dilemmas	McCormick	(P/A)
	DECEMBER			
JH/MB	4, 5	Advanced Pediatric Life Support	Seward	(P)
JH	7, 8	Advanced Cardiac Life Support (Cert/Recert)	Dunn	(P/A)
	JANUARY		Wulfestieg/	
	TBA	Ear/Nose/Throat in General Practice	Rone	(P)
STJ	24	Law & Medicine	Malden	(P)
	FEBRUARY		Pomeroy/	
JH	7, 8	Orthopedics and Sports Medicine in Family Practice	Bargren	(P)
	TBA	Hospital Budgeting		(A)
	MARCH			
JH	14, 15	Tacoma Academy of Internal Medicine	Ames	(P)
JH	16	Day of Pediatrics/Poisoning	Scherz	(P)
	APRIL			
UPS	12, 13	Surgical Club	Martin	(P)
STH	TBA	Neurology	Overfield	(P)
	MAY			
JH	14	Common Office Procedures	Klatt	(P)
JH	23, 24	Cardiovascular Disease Review	Strait	(P)
	JUNE			
	TBA	TPN	Pelham	(P/A)
	TBA	Advanced Cardiac Life Support	Dunn	(P/A)

Dates are subject to change—Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and/or have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137

Medical–Legal Seminar Scheduled for January 24, 1984

An interesting and practical seminar with topics to interest the entire membership with excellent speakers.

Mark your calendars.
Topics being considered are:

- *Informed Consent*
- *Termination of Life Support*
- *What to Look Out For in Contracts Between Physicians and Healthcare Providers*
- *Embarrassing Questions in the Courtroom*
- *Some Lessons From Recent Malpractice Cases*

Speakers who have accepted to address the Seminar are Supreme Court Justice Vernon Pearson, Superior Court Justice Robert H. Peterson, Mr. Jack G. Rosenow, Mr. Frank Burgess, Keith B. Tucker, MD, Don C. Pearson, MD, LLD

PPO's and Contracts: What a Physician Should Consider

By Susan B. Waters, Executive Director, San Francisco Medical Society

Reprinted with permission, San Francisco Medicine, July, 1984

Contracting—A Year Revisited

During the past year I have been aware of more than one hundred organizations calling themselves preferred provider organizations (PPO's) and offering, or planning to offer, contracts to physicians. I have prepared detailed analyses of more than thirty—each different from the one before. But six areas of concern have emerged. This article summarizes these areas. These are presented as generic guidelines to assist you in contract evaluation.

I. The Organization

What is the organization offering the contract? Is it reputable, and does it have a track record of reliability and success? Occasionally, the same names are connected with several successive ventures, each with questionable accomplishments. If the principals are entrepreneurs, are they likely to make the financial and organizational commitments necessary to get the program operating, or are their expectations unrealistic?

If the organization is a physician association, are the organizers willing to put in the hours of work necessary? Does the organization have a clear purpose? Is it adequately capitalized? If a hospital or other institution is providing essential services, such as paying legal costs, is there a clear understanding of where physician interest may diverge, including a system for accommodating that divergence? Who are the association's advisors, and what are their credentials?

II. The Utilization Review/Quality Assurance Program

Since the meat of most contracting arrangements is the UR/QA plan, it should be reviewed carefully. Is the plan clearly spelled out? Who will set the rules and regulations as time passes? Will physicians have adequate input into the process? Will physicians be given enough notice to resign prior to implementation if the plan becomes unacceptable?

Who will conduct UR? Will there be a peer-to-peer contact prior to denial? Does the organization have a record of fairness and even-handedness? Do the protocols protect the patient adequately?

III. Opt In/Opt Out

Does the contract cover one specific program or might other contracts be added in the future? If the latter, is the physician pre-agreeing to all future contracts, or will an offering be made? Does the physician sign up for future contracts, or will failure to refuse within a specified period be considered acceptance? If refusal is required, is the time allowed adequate?

Similarly, is there a requirement to accept a minimum number of patients, or all referrals from the plan? Can the physician exercise normal discretion regarding acceptance of particular individuals?

IV. Dispute Resolution

Is a system established for both internal and external review of disputes about acceptance and termination, UR/QA decisions and other potential areas of conflict? Is the system fair and reasonable? Is it workable?

V. Termination

Can the physician terminate the agreement in a reasonable period if the plan becomes unacceptable?

VI. Business Decisions

In addition to the generic issues listed above, each contract elicits a number of commitments that the physician must consider in light of his or her office operations. I list a few as examples:

Is the fee schedule acceptable? If a period for filing claims is specified, can it be met? Can the physician's office staff handle the administrative aspects of verifying coverage, requesting prior authorization, etc? If a claim form is specified, can the office adapt? Is the record retention and inspection system reasonable? If professional liability insurance is required, does the physician have it, and to the necessary limits? What about the office insurance, is it adequate? Can the office staff keep up with the variety of plans, coverages and other requirements?

Editors note: Look for a more in-depth discussion on PPO's and contracts in your December issue of The Bulletin.

Increasing Number of Syphilis Cases Reported Since July

From: Tacoma–Pierce County Health Department

The Tacoma Pierce County Health Department's Sexually Transmitted Disease Clinic normally sees few infectious cases of syphilis (primary or secondary) on a monthly basis (1-2 cases), but in late July a significant number of new infectious cases began to appear in the STD Clinic. Since then the private community has also seen new infectious cases.

The total number of new cases by the end of September was 13 of which there were 6 primary cases with lesions, 5 secondary cases with rashes, and 2 cases that were less than one year in duration. (The last reported infectious case prior to July was seen in March of this year.)

A cluster of 7 of the cases seem to be related and investigation by the Health Department's Communicable Disease Investigator's have uncovered another 3 cases outside Pierce County. The STD Clinic has also examined 17 sexual contacts who were either not infected or given prophylactic treatment. Two of these contacts who received preventive treatment were pregnant women.

The majority of the cases in this outbreak have been heterosexual. The largest cluster has been associated with patrons of downtown taverns, especially along Pacific Avenue.

For the private practitioner the most significant aspect of this outbreak is that two cases were presented to the private community and were not tested.

Eleven remaining cases were seen in the public clinics and were tested. One of the two cases presented in the private community demonstrated the classic palmar and plantar rash, yet syphilis was not ruled out.

Practitioners should be alert to any signs or symptoms that might suggest a diagnosis of syphilis. The Health Department's STD Clinic can perform darkfield examinations on any suspected lesion to assist in rapid diagnosis. Otherwise an RPR is a sensitive test in early syphilis. A reactive RPR should be followed with a VDRL and FTA.

It may be that the incidence of infectious syphilis will return to its usual status but practitioners should be on the alert and suspect syphilis when any symptoms of "the great imitator" are noted.

Primary Symptoms Usually a singular lesion (occasionally multiple lesions) that occur on the genitals, rectum or mouth. These lesions are normally firm, indurated and range from 1-2mm to 10-20mm. They are typically painless with a regular raised border that is firm and often with accompanying lymphadenopathy.

Secondary Symptoms Symptoms vary greatly and may present as a combination of any of the following: Rash; multiple lesions; moist wart-like genital papules; alopecia; mucus patches of the mouth, throat or cervix; or generalized lymphadenopathy. The most frequent presentation, though, is a rash and a palmar/plantar rash is a strong indication of secondary disease.

Please call Dr. Michael Goerss or Jack Jourden at the STD Clinic (591-6407) for any further information or to report any case. ■

Women in Medicine

What is it like to be a woman and a doctor. According to a recent series of interviews conducted over the past two months for *The Bulletin*, women doctors are as concerned as their male colleagues when it comes to their profession. The overriding concern throughout the interviews was being a good doctor and providing the best care possible for their patients. Jockeying schedules, working out family relationships, deciding when and if to get married and have a family were all taken in stride. For some, however, the decisions came more easily than for others.

For Dr. Cynthia Wilson, recently married, setting up a practice came right along with a wedding. "I had two lists," she says, "and I tried not to get them confused."

Without exception, however, medical schools seem to be where women doctors experience the greatest degree of discrimination. Dr. Eileen Toth, graduating in 1972 from Harvard Medical School, completed her internship and a 2-year residency in internal medicine at Harlem Hospital in New York City.

"We had," she says, "the sickest of the sick with the overwhelming majority either drug addicts or alcoholics. I had no way of dealing with their addiction."

Still, Dr. Toth says she did not feel much discrimination during her internship or residency. Nor, she says, "does she find much discrimination in her everyday life." But during Dr. Toth's training in medical school she remembers clearly when the Chief of Surgery at the hospital where she was doing her surgical rotation told her "women were not suited to careers in surgery."

Out of a class of 120 beginning medical students in Dr. Toth's class there were 12 women, a 10 percent ratio.

"There was dialogue between all the medical students," says Dr. Toth," but there was definitely discrimination from the professors."

According to Dr. Toth, there were no women professors, one woman psychiatrist and one woman who had a chair in anatomy.

"I had no real role models. The clinical staff was almost all men."

Dr. Wilson considered herself a pioneer when she entered medical school in 1976 at Washington University, St. Louis, Missouri. There were 13 black students, five were women. Dr. Wilson was one of the five.

According to Dr. Wilson, medical school was difficult for all the students. But there was less intermingling with the professionals and the women students than there was with the male students. "Particularly," says Dr. Wilson, "in the residencies."

"When I first came to the residency program there was only one other woman," says Dr. Wilson who took her residency in the Tacoma Family Residency program. "The only invitation I had during my residency," says Dr. Wilson, "was during my last year when Dr. Zacharia, a woman obstetrician invited me to her home. I missed, as a young intern, the socializing and support my male colleagues received from attending."

"For family practitioner Dr. Shirley Deem, a 1970 graduate of Washington University Medical School, the atmos-

Dr. Cynthia Wilson

Dr. Eileen Toth

phere of medical school was demanding.

"I had no support," she says, "only my own determination and perseverence."

When Dr. Deem graduated from medical school there were nine women including Dr. Deem who graduated out of a class of 120 students. Fourteen women had started at the same time she had.

"We had to maintain an independent attitude," she says. "There was no coddling."

"I had to make an extra effort," says Dr. Deem, "to keep communication open, and often I had to take the first step to discuss a medical problem."

According to Dr. Rosemary Crawford, a graduate of the University of St. Andrews in Scotland, medical school forced instant maturity.

"I was," she says, "totally unprepared for what I landed into. I had met my nemesis. I encountered patients I had no answers for. I had to start to grapple with the art of medicine, to deal with human beings. I had to learn to be a good listener, a careful historian and face the stresses that came with making up human life."

Dr. Crawford, who set up her own practice in London, England, in 1973, after teaching anatomy and medical illustration at St. Andrews and doing emergency work at Colchester and St. Georges Hospital in London, says she never really felt any discrimination. "But," she says, "Scotland was more liberal than England in admitting women. Very few women were admitted in England until after the second World War."

"It was," she says,"perhaps because they thought women were too delicate to handle the profession."

Coming to the United States from England in 1980, Dr. Crawford says she thoroughly enjoys practicing in the United States and finds the medical profession far better off than in England. She has found, she says, "the medical profession here more friendly, supportive and more willing to see patients."

"In England," she says, " it was more difficult to admit patients to hospitals, especially the elderly. There was more demand on the profession and no restrictions on access."

"The doctors," says Dr. Crawford, "were thoroughly overloaded and overworked. There are no nursing homes in England, no place for the elderly, and your patients were limited to either the hospitals or the office. It was like living in a pressure cooker all the time."

Dr. Crawford sees the need for more publicity in terms of what doctors are do ing and what changes are taking place in the medical profession; and, she says, "We should use good sense and be sensitive to patients' financial problems."

With more women entering the field of medicine in the United States will the practice of medicine change? Perhaps.

According to Dr. Crawford, the medical profession may see a swing back toward the general practitioner, where a greater percentage of women doctors are, and away from the specialties that have been, to a great extent, dominated by their male colleagues."

"The general practitioner," she says, "is the stable part of the medical team. They need to be around to tie up the loose ends."

Dr. Crawford, too, finds that women patients, often, are more comfortable with a woman doctor.

"Women doctors sometimes understand more about women's problems and are more conscious of family problems and how they impinge on a patient's health," says Dr. Crawford who filled in on occasion for the Elizabeth Garrett Anderson Hospital in London when she had her practice in London. According to Dr. Crawford, the hospital, named after the first woman doctor in England, was established during the turn of the century for women doctors to treat women patients.

According to Dr. Deem, the medical profession is a "good profession for women." "They can utilize their softer strengths, their gender strengths."

Dr. Eileen Toth

Dr. Shirley Deem

Dr. Cynthia Wilson

Women in Medicine continued on next page

Women in Medicine
continued from previous page

"Patients," she says, "will seek out a woman physician for understanding. Men will seek them out because they don't want to say, 'I hurt,' to a male physician."

Dr. Deem, however, thinks the medical profession may be facing the loss of independence because of escalating health care costs. She contends that doctors, regardless of gender, need to become more organized, more politically active and more clear in their responses.

"Health care costs," says Dr. Deem, "are not all physicians' fees. It is an accumulation of procedures. The public expects care, the latest in technology. It is not possible for a minimum price, and underpaying the physician is not the answer."

"Physicians," says, Dr. Deem, "should be more involved in analyzing, especially the patients' expenses in hospitals. Otherwise our freedom to practice medicine will be altered, including the quality of medical care."

If the increasing number of women entering the medical profession does impact the practice of medicine, it will, in all probability, be in terms of developing a greater sensitivity toward the patient's entire well-being.

"I have to believe," says Dr. Cynthia Wilson, "that regardless of the coming economic and political struggles, patient care will be of primary concern, and the patient, as a whole, will be considered, that is to say, what is going on inside and around the patient." ▪

Note: There are currently about 30 to 35 women doctors who are members of the Medical Society of Pierce County.

Women in Medicine Pierce County 1900

Women began to make waves in the medical profession as doctors near the turn of the century. In 1900, 18 women's medical schools flourished in Boston. About 20 percent of Boston's doctors were women in 1890.

Pierce County had its own women doctors during its pioneer days. Among the earliest was Dr. Alice Maude Smith. Dr. Smith arrived in Pierce County in 1898 and practiced until shortly before here death in 1938. According to her biography, she was the "first woman physician who was a member of the State Medical Examining Board, the first women to be called upon as an expert witness in the federal courts and the first woman to hold the chair of social hygiene in any college in the country."

Outstanding among her medical achievements was a job she held as an alienist, a specialist in legal aspects of psychiatry.

Born in Quebec, Canada, Dr. Smith was also a prodigious writer. She authored a play, "The Strength of the Weak," which was successfully produced on Broadway, made into a movie and played in the Tacoma Theater starring Florence Roberts.

She was also honored by nomination to the Royal Society of Fine Arts in London England.

Another early Pierce County doctor was Elizabeth Drake. Dr. Drake came to Tacoma with her parents from South Dakota in 1888. She graduated from the Tacoma public schools and attended Annie Wright Seminary. She took her premedical training at Leland Stanford University, California. Graduating from the University of Oregon Medical School in 1907, she went on to do post-graduate work at the Woman's College of Philadelphia and the New York Post-Graduate School. She later did further post-graduate work at John Hopkins Hospital in Boston and at the Mayo's clinic.

An early member of the Medical Society of Pierce County and the Washington State Medical Society, Dr. Drake assisted the noted surgeon Major E.M. Brown for nine years. Specializing in the diagnosis and diseases of women, Dr. Drake was the deputy city physician in Tacoma for three years and the school physician for another two.

After her father's death in 1923 she went to live with her mother on Prospect Hill where she continued to live until her death in the 1970s. ▪

Fannie C. Paddock Who Was She

One of the most famous names in early medical history is Fannie C. Paddock, yet she never set foot in Tacoma.

Paddock, wife of the Rt. Rev. John A. Paddock, appointed in 1881 as Protestant Episcopal Bishop for Washington Territory, was waiting in New York City to begin her trip cross country to Tacoma, her new home when she learned of the lack of hospital facilities in Tacoma. She began to collect funds for the hospital, continuing her efforts en route. She died, however, in Portland before she could complete her journey.

A year later, in 1882, The Fannie C. Paddock Memorial Hospital was dedicated in her honor. The hospital still exists now as Tacoma General Hospital.

AUXILIARY NEWS

Auxiliary Meeting November 16:

The Auxiliary will have its next meeting November 16 at 10:30 with an 11:00 lunch. Mary Lou Jones will be our hostess. Bev Graham is in charge of the lunch. Sharon Lukens will moderate a panel discussion on "Substance Abuse in the Medical Family." Participating on the panel are: Dr. Charles Anderson; Sandy Camp, RNBSN; Dr. Roy D. Clark, Jr.; and "JoAnne," the spouse of a recovering physician. Come and join us. Call for reservations—Ruby Ward, 272-2688; Jane Nowogroski, 565-2887 or Florence Dean, 1-265-2112.

Washington State Medical Association Auxiliary Attends Fall Convention

Several Pierce County Medical Auxiliary members attended the Washington State Medical Auxiliary Fall Convention this last month held at the Westin Hotel, Seattle.

Auxiliary President Sharon Lawson gave a presentation that included a video tape on parenting. Moderated by Jean Enerson, KING-TV, the presentation, which was well received, will be available soon to use in the county.

Several presentations were given, including one by Dr. John Robertson who spoke on preventative medicine in the 80s. The most important factors to your good health, according to Dr. Robertson, were periodic screening exams, diet, exercise, and no smoking.

Address Correction:
If you have moved, let Candy Rao know your new address. Call her at 839-9366.

Finance Committee Report

9-18-84

The Finance Committee chairman has received twelve applications for our philanthropic funds for 1984-85. This committee will meet to select the recipients in October, report to the Pierce County Auxiliary Board November 5, and announce the selections at the general meeting November 16.

The applicants are: Washington Women's Employment and Education Inc., Pierce County Tel-Med Society, Mary Bridge Maternal and Child Clinic, YWCA Women's Support Shelter, Family-Birth to Three Parent Support Program, Pierce County Rape Relief, Planned Parenthood of Pierce County, Catholic Community Services Elderly Respite Program, Christmas House of Tacoma-Pierce County, Center for Child Abuse Prevention Service, Disabilities Law Project, and Council on Child Sexual Abuse. Most of these applicants relate to our national, state and county emphasis on health family living.

Reminder: Comments on the applicants are to be directed to Jo Roller, Finance Chairman (752-6825). Your comments and the applications will be reviewed by the committee before October 31.

Jo Roller
Finance Chairman

Board Meeting, November 5

Open to the general membership, the November 5 Board Meeting will begin at 10:30 with a presentation on coping with the loss of a spouse. Attending the meeting will be Washington State Auxiliary President, Erselle Eade, and President-Elect Sue Dietrict.

You will also be able to find out how you can get AMAA to keep a record of your volunteer activities to help you prepare a resume. The meeting will be held in the Classroom at Lakewood General Hospital.

Reservations for the meeting and/or the no host luncheon following the meeting must be made. Send a $7.50 check, payable to PCMSA, to Phyllis Pierce at 11 Creekwood Ln., S.W., Tacoma, 98499 by October 26. Call Phyllis, 584-9240 or Sharon, 564-6647 if you are planning to just attend the board meeting.

Auxiliary News continued on page 20

Hospital News

St. Joseph

Surgeons Using Ultrasonic Aspirator for Tumor Removal

Surgeons at St. Joseph Hospital are using a newly acquired ultrasonic aspirator to remove tumors. More commonly called the CUSA, the new equipment puts Tacoma abreast with the latest advancement in surgery.

The CUSA (Cavitron Ultrasonic Surgical Aspirator) excises tumors on the brain and in delicate areas of the spinal cord. It is also gaining wide acceptance for general surgical procedures, including delicate liver and kidney surgery.

The CUSA has an ultrasonically powered handpiece with a hollow titanium tip that vibrates at 23,000 cycles per second. This separates and microscopically fragments pieces of the tumor which are automatically removed from the surgical field by suction. The technique allows solid tumor tissue to be fragmented and sucked away with greater accuracy and precision a layer at a time.

There are no sharp edges and no pulling and tugging on surrounding tissue. The CUSA helps remove a tumor totally without damaging healthy tissue with less risk of inadvertent perforation of blood vessels or other sensitive structures.

ER Medical Directors Appointed

Dr. Eric Platz and Jorge Llera have been appointed Medical Directors for St. Joseph. Dr. Platz was appointed as Medical Director of St. Joseph Hospital Emergency Department. Dr. Llera is the Medical Director for the Federal Way Emergency Center of St. Joseph Hospital. Dr. Platz can be reached at 591-6665 or 591-6709; Dr. Llera at 952-3420 or 591-6709.

Multicare

MultiCare Medical Center Has CarePlus Telephone Reassurance Line

MultiCare Medical Center CarePlus Telephone Reassurance Line offers a free daily health and safety check for the frail and homebound. The program, staffed by volunteers, calls homebound people daily to check on them and to chat.

The program provides reassurance for concerned friends and family that a frail, isolated, or homebound person is safe at home. Volunteers are trained to contact qualified medical help, notify physicians or call families and neighbors in case of emergency. If someone had an accident or became ill over night, they can inform the telephone volunteer who will call needed assistance. Volunteers have phone numbers of neighbors and will call to ask them to personally check on a recipient if necessary.

The daily calls also can ameliorate some of the homebound person's feelings of loneliness and isolation. "Many older people who live alone use the telephone as their link to the world," says Karin Miller, Program Director and Geriatric Program Development Coordinator at MultiCare Medical Center. Professionals, physicians, and their staffs often do not have time for lengthy daily calls. Now, they can refer those lonely individuals to the CarePlus Telephone Reassurance Line."

Last month a volunteer called one recipient and was surprised and concerned when the gentleman was not home. She knew that he spent most days on the couch with the phone nearby. After trying to call him several times she called his neighbor to ask her to go next door and check. The neighbor relieved all concern by saying the man felt well and had come to her house for a visit. In this case, there was no cause for alarm, but it was rewarding to see the system work. The calls can make a critical life saving difference.

There is no charge for the program. The callers are volunteers from CarePlus and MultiCare Medical Center's Office of Geriatrics and Long Term Care. Currently 25 people are being called.

To include someone in the Telephone Reassurance Line Program, call Karin Miller 594-1370.

Hospital News continued from page 19

Tacoma General

Kudos and Thanks to MD Golfers

The 14th Annual Tacoma General Hospital Auxiliary Golf Tournament was held September 7, 1984, at the Tacoma Country and Golf Club. This very successful event included 129 golfers and resulted in a donation of $10,083 for the new Heart Care Center at Tacoma General.

Added to money raised this year through other events, the Auxiliary will fund the $10,000 Equipment Transport System and purchase two Venti Voice Communication Systems at $1,125 each. An as yet unspecified amount will be given for Nursing Education Programs for the Heart Center.

Tacoma General Hospital Auxiliary would like to thank the sixteen physicians that entered the tournament this year. Dr. Doug Macleod won Low Gross, Division C, and Dr. Walter Sobba won Second Low Net, Divison A. Dr. Macleod's name will be added to the plaque in the physician's lounge as this year's winner for Low Gross.

Also participating were Drs. Stephen Annest, John Bargren, Wayne Bergstrom, John Comfort, J. Antonio Garcia, Robert Gibson, David Lee, John May, William McPhee, William Rohner, John Rowlands, Marshall Whitacre, and Howard Wong.

Dr. Samuel Adams was unable to play the day of the tournament. The following wives of physicians won prizes also: Betty May, Low Gross, Division B; Rita Bergstrom, Second Low Net, Division B; Maggie Comfort, Least Putts, Division B; and Barbara Wong, Long Drive, Division A.

The continuing support of the physicians is greatly appreciated by the Hospital Auxiliary members.

Auxiliary News continued from page 19

Christmas Shopping? Why Not Support the AMA-ERF Fund

The Auxiliary has some gift items available for your Christmas list that will benefit the AMA-ERF fund. Available are apple pins, aprons and tote bags (a new item). They will be available at the Nov. 16 meeting. Look for Nikki Crowley.

Auxiliary News continued from page 20

Auxiliary Membership Increasing

Auxiliary membership is increasing! New members, reinstated members and ongoing members are getting their dues paid and dues collections are far ahead of last year.

Pay your dues now so that you can participate in all the extra activities planned for 1984-85. Send a $38.50 check, payable to PCMSA to Shirley Murphy, 3109 N. 33rd St., Tacoma, WA 98407.

MD Dissatisfaction Predicted, continued from page 9

Medicare eligibility would be raised (93%), and that physicians would be forced to accept assignment (90%).

Diagnosis-related groups

- Most respondents said that by 1990, Medicaid, Blue Cross and the commercial insurers would adopt diagnosis-related groups (DRGs) as a payment mechanism.

Physicians

- Because of DRGs, there will be a trend toward prescribed diagnosis and treatment, physician and hospital respondents agreed.
- Nearly eight out of 10 physicians predicted more competition and conflict within the profession.
- A majority of physician and hospital respondents predicted that physicians would derive less satisfaction and less income from their practices.

The job market

- Ninety-eight percent of respondents predicted that in 1990 there would be an oversupply of physician specialists; two-thirds predicted an oversupply of general and family practitioners.
- Eighty percent predicted an oversupply of hospital administrators.
- Sixty percent predicted a shortage of computer personnel.

Hospitals

- Inpatient use of hospitals will decrease, but outpatient services will expand substantially.
- Multihospital systems—both proprietary and non-profit—will account for 40% of community hospitals by 1995.
- The ability to obtain capital will be a key financial issue for hospitals.
- Eighty-five percent of respondents expected for-profit hospital chains to be more profitable in 1990 than today.

An Arthur Anderson spokesman said the accounting firm has spent "in the six figures" financing the study. The ACHA, which contributed personnel and expertise to the project, is a professional society of hospital administrators.

The study is available for $65 from Arthur Anderson, c/o Compuletter, 5616 N. Western Ave., Chicago, Ill. 60659. ▪

From: American Medical News, Sept. 7, 1984

MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

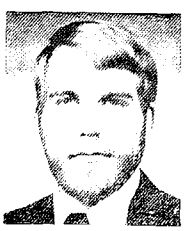
Harold G. Brandford, MD, *Anesthesiology.* Born in Barbados 5/21/49; medical school, Cornell Univ., New York, 1976; internship, Univ. of California, San Diego, 7/76–6/77; residency, Univ. of California, San Diego, 7/77–6/79. Washington State License, 1979. Dr. Brandford is currently practicing at 314 South "K" Street, Tacoma, Washington.

Henry S. Krueger, MD, *Internal Medicine.* Born in Portland, OR, 5/25/50; medical school, Univ. Texas H.S.C.D., Southwestern Medical School, 1981; internship, Univ. Miss. Med. Ctr, Jackson, MS, 7/81–6/82, residency, Tulane Univ. School of Med., New Orleans, LA, 7/82–6/84. Washington State License, 1983. Dr. Krueger is currently practicing at 7424 Bridgeport Way West, Tacoma, Washington.

Jerry J. Sullivan, MD, *Family Practice.* Born in Butte, MT, 6/10/51; medical school, Creighton Univ. School of Med., Omaha, NE, 5/21/77; internship, Madigan Army Med. Ctr., Tacoma WA, 7/77–6/78; residency, Madigan Army Med. Ctr., Tacoma, WA, 7/78–6/80. Washington State License, 1978. Dr. Sullivan is currently practicing at 1112 South Cushman, Tacoma, Washington.

Walter D. Fife, MD, *Orthopaedics.* Born in New Orleans, LA, 1/31/37; medical school, Louisiana State Univ., New Orleans, LA, 6/3/67; internship, LDS Hospital, Salt Lake City, Utah, 6/67–6/68; residency, Charity Hospital, New Orleans, Orthopaedic, 7/68–6/69, Touro Infirmary, New Orleans, 7/69–6/70, Charity Hospital, 7/70–6/71, Touro Infirmary, 7/71/11/71, Earl K. Long Hospital, Baton Rouge, 11/71–2/72, Touro Infirmary, 3/72–6/72. Washington License, 1974. Dr. Fife is currently practicing at 124 Tacoma Avenue, Tacoma, Washington.

Douglas Malo, MD, *Orthopaedics.* Born in Dallas, OR, 1/16/53; medical school, Univ. of Oregon Health Science Center, Portland, OR, 6/8/79; internship, Mayo Graduate School, Rochester, MN, 7/79–6/80; residency, Mayo Graduate School, Rochester, MN, 7/80–6/84. Washington State License, 1984. Dr. Malo is currently practicing at 212 South "J" Street, Tacoma, Washington.



Michael Goerss, MD, *Internal Medicine.* Born in St. Louis, MO, 5/6/54; medical school, Loyola-Stritch School of Medicine, 6/80; residency, Mayo Graduate School, internal medicine, 6/80–6/83; graduate training, Mayo Graduate School, emerg. medical services. Washington State License, 1984. Dr. Goerss is currently practicing at 3629 South "D" Street, Tacoma, Washington.

Alan E. Shelton, MD, *Family Practice.* Born in Tokyo, Japan, 3/14/54; medical school, University of Oregon Medical School, 6/12/81; internship, St. Francis Regional Med. Ctr., 7/81–6/82; residency, St. Francis Regional Med Ctr., 7/82–6/84. Washington State License, 1984. Dr. Shelton is currently practicing at 2209 East 32nd, Tacoma, Washington.

Medical Society of Pierce County

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

"CORPORATE PRACTICE OF MEDICINE"
NOVEMBER 13 GENERAL MEMBERSHIP MEETING NOTICE

FOR PROFIT. . . . NOT FOR PROFIT?

"Within the next 25 years. . . a majority of hospital beds will be Corporate owned"
Stanley M. Wohl, M.D.
The Medical-Industrial Complex

How will the Doctor interact with the Corporate World???
What is the Bottom Line. . . Budget or Quality of Care???

HEAR: Turner Bledsoe, M.D., Medical Director
Group Health Cooperative of Puget Sound
Seattle, Washington

DATE: Tuesday, November 13, 1984

PLACE: Fircrest Golf Club
6520 Regents Blvd.

TIME: 6:15 pm—social hour
7:15 pm—dinner
8:00 pm—program

COST: Dinner, $13.50 per person.
(price includes tax and gratuity)

Register today. Space will be limited. Mail this form, with a check for the appropriate amount, to the Medical Society in the business reply envelope provided. Or, call the office, 572-3667, to confirm your attendance. Make check payable to Medical Society of Pierce County.

REGISTRATION

Yes, I have set aside the evening of November 13 to hear "Corporate Practice of Medicine."

☐ Reserve _____ dinner(s) for me at $13.50 each (price includes tax and gratuity).
Enclosed is my check for $_____.

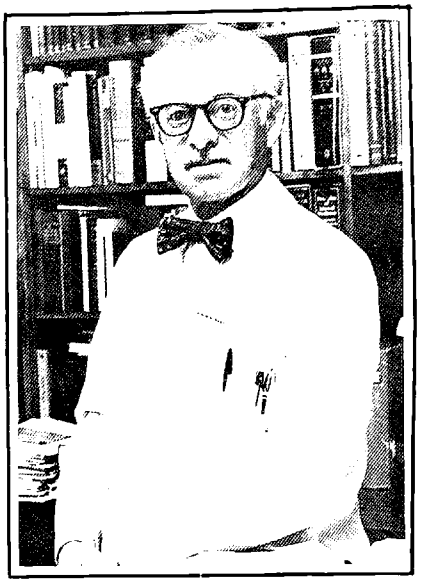
Dr. _____ Telephone _____

RETURN TO MEDICAL SOCIETY OF PIERCE COUNTY NO LATER THAN FRIDAY, NOVEMBER 9

1984

Edwin C. Yoder

Honor Lecture



MAXWELL MYER WINTROBE

Maxwell Myer Wintrobe has received many honors recognizing his international contributions to the field of medicine and specifically to hematology. He is the author of over 400 journal articles and presented the leading textbook of clinical hematology originally in 1942 and subsequently published in many languages. He has co-edited "Harrison's Principles of Internal Medicine" and written full texts and treatises in his field of hematology as well as others. He has many honorary doctorate degrees recognizing his eminence as a student, teacher and lecturer in medicine. He continues his active work at the University of Utah Medical Center in Salt Lake City, Utah.

Guest Speaker

Maxwell M. Wintrobe, M.D.

Friday, November 16, 1984

St. Joseph Hospital and Health Care Center

PHYSICIAN LECTURES

10:00 A.M.	"Hematology Today"
12:15 P.M.	Complimentary Luncheon
1:15 P.M.	"The Blossoming of a Science" — Honor Lecture —

NURSING/PARAMEDICAL LECTURE

3:30 P.M.	"The Blood & Blood Disorders"

For tickets and further information, contact the Medical Director's Office, **591-6767**

Looking for a market?

Advertise in The Bulletin, the Medical Society's publication.

For information on advertising rates and space available,
Call **564-3831,**
or come by our office at
2607 Bridgeport Way West, Suite 2C
in Tacoma.

A WORD TO THE WHYS

WHY AMA?

The AMA actively works to represent your interests by fostering legislation that is beneficial both to the medical profession and the public. Each year the AMA makes thousands of contacts with members of congress and their staffs and frequently translates Association policies into model or draft legislation for governmental action. Active representation of organized medicine: it's one more good reason why you should be part of the AMA.

WHY AMA? Today you can have instant access to a broad range of up-to-the-minute clinical information and protocols for use in patient care through the Medical Information Network. This nationwide, computerized system was developed by the AMA, with General Telephone and Electronics (GTE), to provide you with the most advanced, current scientific information. It's one more reason why you should be a part of the AMA.

WHY AMA? Residents and medical students now have a strong voice in organized medicine. Through the Resident Physician Section and the Medical Student Section, these two groups participate in the policy making process of the AMA and communicate their concerns. Developing future leadership in organized medicine: it's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

MEDICAL SOCIETY OF PIERCE COUNTY
705 South 9th, Suite 203
Tacoma, Washington 98405

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The Bulletin
MEDICAL SOCIETY OF PIERCE COUNTY

December, 1984

Planning to sign a contract?
See page 13

WSMA Annual Meeting:
MSPC Participates.
See page 12

Children's Holiday Party,
Auxiliary News.
See page 18

Medical Society of Pierce County

705 South Ninth Street • Suite 203 • Tacoma, Washington 98405 • Telephone (206) 572-3666

You are cordially invited to join the

Medical Society of Pierce County

and

Pierce County Medical Auxiliary

at their

ANNUAL JOINT DINNER MEETING

SHERATON TACOMA HOTEL

1320 Broadway Plaza

Tuesday, December 11, 1984

Installation of 1985 Medical Society Officers and Trustees

Featuring:

Sumner High School Jazz Band

Under the Direction of Steve Montague

Cocktails (no host) 6:30 p.m.

Dinner 7:15 p.m.

Program 8:30 p.m.

$17.50 per person, $35.00 per couple

(Price includes wine, tax, gratuities)

CHANGING YOUR ADDRESS? HAVE A NEW ADDRESS?

Please fill out this **change of address** card and return to:

Medical Society of Pierce County
705 S. 9th
Tacoma, WA 98405

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_____ PHONE_____

NEW ADDRESS _____

_____ PHONE_____

ld to benefit the Student Recognition
handmade placemats for her and a
or him. Tickets: 6 for $5.00, will be
ocktail hour.

heck for the appropriate amount,
o confirm your reservation.

ember 5, 1984

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loint Dinner Meeting

the Medical Society of Pierce County
eting and Installation of Officers.

on/$35.00 per couple.

$_____

_____

Pierce County

The Bulletin *The official publication of the Medical Society of Pierce County*

In This Issue

Cover Photo: WSMA Annual Meeting. MSPC President Dr. Pat Duffy (right) talking with U.S. Representative Richard A. Gephardt (D-Mo).

Deadline for submission of copy is the 25th of the month preceding the month of publication. However, final determination of publication date will be made by *The Bulletin. The Bulletin* reserves the right to edit all reader contributions for brevity, clarity and length, as well as to reject any material submitted.

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President's Page

A Commentary: In Appreciation of Our Medical Auxiliary

As I have become more involved in the affairs of the Medical Society of Pierce County, I have been made increasingly aware of the strong support of our Medical Auxiliary. Its members work behind the scenes on many projects which have significant impact on our community.

The Auxiliary president each year attends our Board of Directors meetings, listens to the many complex issues discussed and contributes to key decisions. This year, President Sharon Lawson has done an outstanding job on the Board, attending meetings with great regularity and providing for us a monthly report on Auxiliary activities.

In this column, I would like to outline a few of the activities in which the Auxiliary is involved:

The Family—Birth to Three Support Group - This project, staffed by volunteers and one paid member from the County Health Office, is designed to support new parents. Contact is made with these parents while the mother is still in the hospital; volunteers provide answers to the many questions most new parents have. In addition, post-hospital counseling is offered as needed. The project not only increases the confidence of new parents but provides a network for participants who then, it is hoped, support each other in areas ranging from exchange of babysitting to transportation to the doctor's office.

Tel-Med Tape Library - This resource, run primarily by Auxiliary volunteers, is an invaluable service with which many doctors are unfamiliar. I must confess that, until the last couple of years, my knowledge of the Tel-Med Tape library was limited. It can be most helpful in explaining medical questions from patients, and is a great time-saver for individual doctors. I urge you to suggest to your patients the use of this free service to find answers to practically any medical question.

Pierce County Medical Society Auxiliary Health Fair - Each year, this event brings together Auxiliary members and physicians in a fun, educational program for the community.

Auxiliary Support Group - Among the most valuable services provided by the Auxiliary is this support group for its own members. There are times in everyone's life when he or she needs someone to lean on. A fellow member of the Auxiliary who understands the situation so much better than most people do, is certainly an important resource in times of stress.

AMA-ERF - This is a nationwide project to raise money for the American Medical Association Education & Research Foundation. It has been an impressive local success. Our Auxiliary has been number one in the state in the amount raised for nine consecutive years.

There are many other ways in which Auxiliary members contribute to their communities. Thousands of hours of volunteer time are spent each year on the following:

Physicians Speakers Bureau
AMA Education Research Foundation
Pierce County Womens Support Shelter
Handicapped Awareness
Tacoma Public Schools
Pierce County Rape Relief
Good Samaritan Hospital, Childrens Unit
Good Samaritan Hospital, Adult Therapy Unit
Mary Bridge Childrens Hospital
Tacoma Day Nursery
Remann Hall
Catholic Childrens Services
YMCA Handicapped Swim Program

But, the Auxiliary contributes dollars as well as volunteer time. Each year, thousands of dollars are contributed to a host of community projects, including Women's Employment and Education, Equest, St. Ann's Home, Tel-Med Tape Library and Tacoma Public Schools. These hard-earned dollars are wisely allocated by the Auxiliary, which gives me a chance to plug the group's annual fund-raiser. This year, it will be a raffle and champagne brunch on March 17, 1985, a day dear to my (Irish) heart.

As President of the Medical Society of Pierce County and spokesperson for member doctors, I want members of the Medical Auxiliary to know we appreciate, admire, encourage and support you in all your endeavors. If I have encouraged any person to volunteer her services through the Auxiliary, please contact Beverly Law at 564-6515. I am sure she can find a satisfactory placement for your talents!

—JPD

LOCAL NEWS BRIEFS

Former MSPC President Dr. Charles Larson dies

The medical community was saddened to hear of the death of Dr. Charles Larson. Dr. Larson was active in the Medical Society of Pierce County and was president in 1967. Known worldwide for his knowledge of forensic medicine, Dr. Larson was founder and president of the American College of Forensic Pathologists. Dr. Larson is survived by his wife, Margaret; his son, Dr. Larry Larson; three other sons and three daughters. *(The Bulletin will publish a brief memorial on Dr. Larson with the January issue.)*

MSPC Board of Trustees meets with Director of Pierce County Children and Adult Protective Services

MSPC Board of Trustees met in special session with Mr. Gene Zinck, Director, Pierce County DSHS Children's and Adult Protective Services. At issue was the continuing problem of communication between the Children's Protective Service and the medical community.

As a result of the meeting, the Society and the Children's Protective Services will be developing a *Memorandum of Understanding*. Members of the MSPC Executive Committee, Washington State Medical Disciplinary Board, Children's Protective Services and Pierce County Prosecuting Attorney's office will meet November 14, to establish guidelines for communication between the various parties to remove the possibility of any future misunderstanding.

Pierce County Council passes smoking ban in 7-0 vote

The seven member Pierce County Council approved unanimously at the October 30 meeting of the council a no-smoking ordinance for unincorporated areas of Pierce County. The new law will take effect January 15, and will be reviewed after one year. The ordinance, strongest in the state, was supported by over 600 physicians from MSPC.

Close to 75 people attended the council meeting. MSPC President Dr. Pat Duffy, Pierce County Health Director Dr. Bud Nicola along with Drs. Alan Tice, Terry Torgenrud and Bruce Smith spoke in support of the ordinance. Dr. Torgenrud spoke on behalf of the "children who could not speak for themselves."

Dean Morgan, representative of the Tobacco Institute was the only person, according to news coverage, that spoke against the ordinance.

According to the *Tacoma News Tribune*, Dr. Nicola told council members 20 percent of the deaths of the nation could be blamed on cigarette smoking. And not all, the newspaper reported Dr. Nicola saying, from direct smoking.

In testimony before the council, Dr. Smith discussed the success of the no-smoking policy at Group Health, pointing out to the council that "not only had employees quit smoking during working hours, but many of them had quit smoking completely." Group Health, he told council members, has been surprised at the success and the small number of problems with the policy.

Speaking on the ill effects of smoking, Dr. Tice told council members, "There is no serious question on the ill effects of smoking, and evidence is increasingly clear on the effects of side-stream smoking. We should respect the rights and health of non-smokers."

The most controversial section of the ordinance applies to private office work areas where smoking would be prohibited if complaints from non-smokers could not be accommodated.

Restaurants will be required to provide seating for non-smokers. Percentages, however, were not specified in the ordinance. The ordinance requires retail outlets and banks to have designated smoking areas.

Passage of the ordinance came after several months of testimony and meetings of ad hoc committee members, Drs. Tice, Smith and George Weis; Attorney Jeff Jahns and Sue Asher, representative of the American Lung Association. Committee members attended several meetings of the Restaurant Association and the Tacoma-Pierce County Chamber of Commerce to work out a compromise solution.

MSPC President Dr. Duffy along with 10 other MSPC physicians testified before

Local News Briefs, continued on next page

Local News Briefs, continued from page 5

an emotionally charged hearing of the Pierce County Council October 2, in support of the ordinance. Ann Browder, assistant to the president of the Tobacco Institute, testified against the ordinance.

News coverage of the council's actions was extensive, appearing in the *Tacoma News Tribune*, the *Gateway Peninsula*, the *Seattle PI and the Puyallup Herald*.

Support Group for Autistic People

The Coalition for Autistic People is a parent support group for parents living in Pierce County who have a child or children with autism. Mrs. Betsy Maier reports that the group meets on the 3rd Tuesday of the month at 7:00 p.m., Birney Elementary School, 1202 South 76th, Tacoma.

The support group includes professionals and other empathetic and concerned persons interested in helping those who have autism as a disability.

According to Mrs. Maier, there is an extensive resource library on autism located in the medical library at St. Joseph Hospital. For additional information on the support group or the library, contact Mrs. Betsy Maier, 564-8487 or Mrs. Mary Christie, 845-0512.

MSPC Auxiliary will hold raffle at Annual Joint Dinner Meeting to benefit Student Recognition Program

A raffle will be held to benefit the Student Recognition Program at the December 11, Annual Joint Dinner Meeting. Prizes will be handmade placemats for her and a box of fine wine for him. Medical Society Auxiliary members will be selling tickets during the cocktail hour. Tickets will go for 6/$5.00. Proceeds of the raffle will go to support the recognition awards for two graduating seniors of physicians' families.

Auxiliary members are asked to bring a wrapped gift for a woman at the Tacoma Support Shelter. Suggestions for appropriate gifts are: books or magazines, stationery with stamps, toilet articles, slippers, cosmetics, etc. Please label the contents of the package on the outside to aid in the distribution of gifts.

Western Clinic opens new Gig Harbor office, Open House, Dec. 2

The Physicians of Western Clinic opened a new Gig Harbor office, November 19, 1984. The 7,500 square foot facility is located on Kimball Drive across from Fire District #5 headquarters. The office was formerly located at #3 Professional Building, Pioneer & Uddenberg Streets.

The new building space will provide space for additional physicians. The Family Practice Department will be expanded and Dr. Mark Craddock will join Drs. Richard Gilbert and Dennis Quiring. Dr. Joan Goerss, a pediatrician, will join the group in November and Dr. Bruce Brazina, an internist, in January, 1985.

Also included in this construction is a Physical Therapy Department, X-Ray and Laboratory facilities, a larger reception area, and a children's playroom. An access for emergency vehicles is also planned.

Physicians interested are invited to attend an Open House on Sunday December 2, 1984, 1:00 p.m. to 5:00 p.m.

continued on the following page

Local News Briefs, continued from previous page

Puget Sound Collections, Inc., sponsors Fall Medical Credit and Collections Workshop

Puget Sound Collections, Inc., sponsored its 2nd Medical Credit and Collections workshop at St. Joseph Hospital Education Center Thursday, October 4, 1984. Principal speakers included Mr. John Grimm, certified instructor for the American Collectors Association and Mr. Keith Oberhansley, Chapter 13 Trustee for the United States Bankruptcy Court. The workshops will be provided annually as a continuing service to Puget Sound Collections, Inc., clients.

Ad Hoc Committee on tympanometry recommends guidelines for student referrals

Several school districts have tympanometers that are used by school nurses in auditory assessments. The student population being screened are pre-school, special education and those who have a presenting history of hearing problems.

There have been no guidelines or standards established for referrals to physicians. The basis for the formation of the committee was concern about the standardization of criteria in the referral process to the physician. The function of the committee is not to advocate the purchase of tympanometers, but to provide guidance for those school districts that have tympanometers.

The committee recommends that the following guidelines be used in referring a student to a physician for further evaluation:

Use of otoscope and pertinent history taken at the time of initial failure of audiometry/tympanometry

Failure of audiogram would follow established guidelines according to WAC's 248-144-090.

Pressure	Acoustic Reflex	Action
–200 to + 100 mm H_2O	*Present*	*Pass*
Outside above range	*Absent*	*Refer*
Outside above range	*Present*	*Retest*
–200 to + 100 mm H_2O	*Absent*	*Retest*

On retest, if both normal - *pass*
if either fail - *refer*

Rescreen tympanometry in four to six weeks, including stapedial reflex (105dB).

If rescreen is failed that student is referred to the parent for medical attention.

Included with referral are:

- *an otoscopic examination of the external canal*
- *pertinent health history*
- *copies of current audiogram and tympanogram*

Ad Hoc Committee Members:
Shirley Baker, RN; Karen Whitmore, RN; Donna Libby, RN; Shirley Carstens, RN; Julia Mueller, RN; Carl Wulfesteig, MD

Biking Through Puget Sound to Improve Everybody's Wind

By Sidney F. Whaley, Jr., MD

Over 180 bike riders took up the challenge of biking from Seattle to Victoria during the last two week-ends in September to raise money for the Washington State Lung Association. The trip took three days. The bikers covered 120 miles and took five ferry rides. The maritime route included a stop at Bainbridge Island, Port Townsend, Whidbey Island, San Juan Island and Vancouver Island.

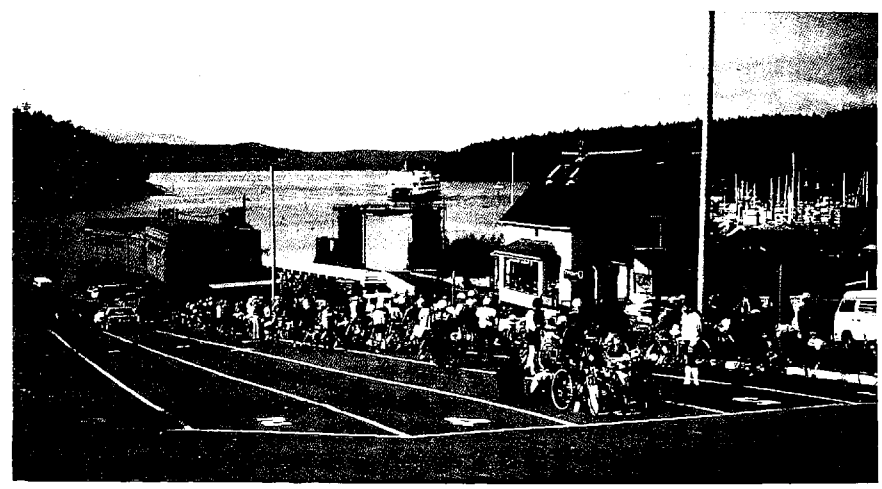
Bikers peddled for 45 miles the first day, 45 miles the second day and 30 miles on the third and last day of the trip. Two MSPC members participated in the challenging ride. Dr. Phil Schultz made the ride during the first weekend. The weather was perfect. Dr. and Mrs. Sid Whaley had a wet send off for their ride on the second weekend, but then found the weather, for the most part, sunny. The bikers raised $130,000 in pledges.

Support vehicles with bicycle mechanics, paramedics and ham radio operators patrolled the route warning cars of the presence of the bikers. The lung association personnel gave a great deal of support and encouragement, particularly at the end of the day when bodies and bicycles often turned cranky.

Bikers spent the first night in Ft. Warden State Park with dinner and breakfast supplied by the Rebeccas of Pt. Townsend. Walking to the eating hall gave the bikers a chance to exercise some different muscles and savor the turn-of-the-century homes.

During the second night a group of tired bikers stayed at Roche Harbor Inn where they enjoyed the pleasures of a pool and dance floor. Swimming laps under the San Juan sunset was pure delight, but a few didn't quite make it to the dance floor. Insomnia was not a problem for anyone during the second night.

During the last day of the trip the bikers traveled 30 miles from Sidney to Victoria passing by elegant residential sections east of town. As Victoria approached, everyone knew there would be no more friendly bikers passing by, no more bakeries to raid, no more friendly check points with smiles and fresh fruit. The realization produced a sense of loss not wholly remedied by the laugh filled ride back to Seattle in the Tarten Lounge of the Princess Marguerite. ■



Photos by Sidney F. Whaley, Jr., MD

1984
MEMBERSHIP OPINION SURVEY RESULTS

The 1984 Medical Society Membership Opinion Survey was conducted in June. Survey results were used by the MSPC Board of Trustees in developing the goals for the Society at the Board's August 18 retreat.

Survey results showed the number one priority of the membership was concern for increasing professional standards and ethics. Implementing efforts to improve the public image of the medical profession received the next highest ranking.

MSPC members encouraged active participation in the Society and in public health issues, such as: air pollution, smoking, water pollution and toxic waste. Survey results further indicated that Society members considered as necessary increased political activity and awareness. The membership continued to voice strong support for the College of Medical Education and the need for local programs. The response rate was 33 percent of the membership.

—the editor

The following results are reported in groups according to number of years the physician has practiced. The numbers in the column entitled "Number Answered" reflect the number of physicians in that group who responded to the question, working on a scale of 1 to 5, with "5" being the most important and "1" being the least important.

	5	4	3	2	1	Number Answered
In Your Opinion, The Society Should:						
A. Provide membership services, such as:						
1. Patient referrals						
Less than 5 years	29%	28%	24%	0%	9%	46
5-10 years	24%	31%	31%	6%	7%	54
Over 10 years	19%	31%	28%	11%	11%	80
	Responded: 192		Average: 3.49			
2. Preparing membership for "competitive era"						
Less than 5 years	31%	30%	24%	0%	4%	58
5-10 years	31%	30%	24%	11%	4%	54
Over 10 years	23%	30%	30%	8%	9%	79
	Responded: 191		Average: 3.63			
3. Medical office placement						
Less than 5 years	7%	19%	40%	1%	16%	57
5-10 years	9%	24%	35%	26%	6%	54
Over 10 years	9%	24%	30%	20%	17%	82
	Responded: 193		Average: 2.92			
4. Addressing and mailing						
Less than 5 years	6%	3%	36%	1%	8%	36
5-10 years	4%	20%	33%	33%	10%	51
Over 10 years	8%	14%	23%	23%	32%	78
	Responded: 165		Average: 2.54			
5. Office supply purchasing						
Less than 5 years	0%	5%	28%	0%	38%	58
5-10 years	6%	8%	19%	25%	43%	53
Over 10 years	3%	8%	19%	26%	44%	77
	Responded: 188		Average: 2.02			
B. Work towards increasing professional standards and ethics.						
Less than 5 years	51%	35%	11%	0%	2%	63
5-10 years	59%	29%	11%	2%	0%	56
Over 10 years	64%	27%	5%	1%	4%	85
	Responded: 204		Average: 4.41			
C. Increase political action and awareness amongst membership.						
Less than 5 years	35%	43%	16%	0%	3%	63
5-10 years	35%	39%	20%	6%	0%	54
Over 10 years	32%	36%	21%	4%	7%	85
	Responded: 202		Average: 3.95			
D. Encourage participation in public health issues, such as:						
1. Air pollution						
Less than 5 years	39%	30%	18%	0%	3%	61
5-10 years	40%	31%	20%	5%	4%	55
Over 10 years	36%	27%	25%	6%	6%	83
	Responded: 199		Average: 3.89			
2. Smoking						
Less than 5 years	50%	26%	16%	0%	3%	62
5-10 years	53%	25%	18%	2%	2%	55
Over 10 years	45%	25%	20%	6%	4%	83
	Responded: 200		Average: 4.12			
3. Water pollution						
Less than 5 years	31%	37%	22%	0%	3%	59
5-10 years	39%	30%	24%	6%	2%	54
Over 10 years	32%	29%	25%	10%	5%	84
	Responded: 197		Average: 3.84			

CONTINUED...

	5	4	3	2	1	Number Answered
4. Fluoridation						
Less than 5 years	28%	33%	21%	0%	7%	58
5-10 years	35%	29%	29%	4%	4%	55
Over 10 years	29%	24%	28%	12%	7%	83
	Responded: 196			Average: 3.66		
5. Toxic Wastes						
Less than 5 years	30%	41%	15%	10%	4%	59
5-10 years	35%	35%	22%	5%	4%	55
Over 10 years	34%	27%	21%	12%	6%	82
	Responded: 196			Average: 3.81		
E. Implement efforts toward improvement of the public image of the medical profession.						
Less than 5 years	58%	27%	11%	0%	0%	62
5-10 years	55%	34%	11%	0%	0%	56
Over 10 years	56%	29%	10%	3%	1%	86
	Responded: 204			Average: 4.39		
F. Provide local CME programs.						
Less than 5 years	48%	33%	11%	0%	3%	64
5-10 years	45%	34%	11%	8%	2%	53
Over 10 years	32%	24%	26%	12%	7%	85
	Responded: 202			Average: 3.93		

	5	4	3	2	1	Number Answered
G. Participate more actively with:						
1. Hospital medical staff						
Less than 5 years	17%	17%	46%	1%	7%	46
5-10 years	13%	33%	33%	15%	7%	55
Over 10 years	30%	28%	28%	6%	9%	80
	Responded: 181			Average: 3.44		
2. Hospital administration						
Less than 5 years	19%	25%	39%	1%	2%	57
5-10 years	11%	33%	31%	19%	6%	54
Over 10 years	33%	20%	31%	6%	10%	80
	Responded: 191			Average: 3.45		
3. Nurses						
Less than 5 years	0%	21%	49%	1%	9%	57
5-10 years	11%	23%	28%	28%	9%	53
Over 10 years	16%	18%	39%	18%	9%	79
	Responded: 189			Average: 3.01		
4. Physical therapists and other para-professionals						
Less than 5 years	0%	11%	53%	1%	18%	57
5-10 years	6%	20%	30%	35%	9%	54
Over 10 years	11%	19%	27%	27%	17%	64
	Responded: 175			Average: 2.71		

	YES	NO	Number Answered
1. Do you have good access to members of the Board of Trustees and Society Committees to express your views?			
Less than 5 years	72%	28%	57
5-10 years	80%	20%	49
Over 10 years	78%	22%	79
TOTALS	77%	23%	185
2. Has the Society office been responsive to your requests for assistance?			
Less than 5 years	87%	13%	46
5-10 years	94%	6%	49
Over 10 years	90%	10%	77
TOTALS	90%	10%	172
3. Are you concerned with the future of the hospital/physician relationship in the "competitive era?"			
Less than 5 years	98%	2%	61
5-10 years	91%	9%	54
Over 10 years	91%	9%	85
TOTALS	93%	7%	200
4. Do you regularly read the Society's Bulletin?			
Less than 5 years	100%	0%	63
5-10 years	98%	2%	56
Over 10 years	94%	6%	84
TOTALS	97%	3%	203
5. Should the Society implement a quarterly dues payment system?			
Less than 5 years	34%	66%	50
5-10 years	37%	63%	46
Over 10 years	34%	66%	80
TOTALS	35%	65%	176

Bill Payment: A Report from the Department of Labor and Industries, Olympia, Washington

During 1983, the Department of Labor and Industries received approximately 100,000 bills a month. In 1984, the bill volume continued at this level. The department paid $113,000,000 for treatment services or approximately $9.5 million per month in 1983. During 1984, the department has paid out the following:

January $10.2 million
February $11.2 million
March $8.5 million
April $5.0 million
May $16.5 million
June $11.4 million
July $5.1 million
August $7.8 million
September $9.0 million

The 1984 average per month is $9.7 million.

In May, providers were offered an interim payment option to receive 80 percent of their Department of Labor and Industries accounts receivable. Approximately 15 percent of the 16,000 providers on file elected this option. During June, July, and August the interim payments credits were used to offset bills processed for providers.

As of September 6, 1984, all bills received in the agency by mid August were in the system. Further, all bills which were correctly presented on open active claims had been paid.

Approximately one month's receipts remained in suspense due to question as to claim status, errors on the bill form, or question as to whether service was allowable. Approximately 60 percent of these bills were from doctors, chiropractors, registered physical therapists, osteopaths, psychologists, and certified registered nurses.

The department and the computer contractor are constantly re-examining the system, the flow process and making adjustments to permit correct payment of bills in an expeditious manner.

Bill payment and clerical staff has been added to assist with bill payment. Staff has been working ten hours per day five days per week since early August.

The following are the most common reasons why a bill suspends:

- *No claim number is on the bill.*
- *The claim number and the name of the claimant on the bill do not match the record in the computer. Usually, this is a transposition error or one digit is missing or the alpha prefix on the claim number is wrong.*
- *The provider's Department of Labor and Industries provider name and/or number is not on the bill.*
- *The provider name and number on the bill does not match the name and number on the Department of Labor and Industries provider file, i.e., the Department of Labor and Industries provider file lists 12345 Brown, John M.D. The bill lists 12345 Seattle Medical Clinic.*
- *The procedure code is missing or wrong or the appropriate modifier has not been used, i.e., -30 anesthesia service; -26 professional component; -80 assistant surgeon, etc.*
- *Units of service are missing or wrong. When billing for services which are measured in time such as physical therapy, anesthesia, psychiatry, biofeedback, etc., the time*

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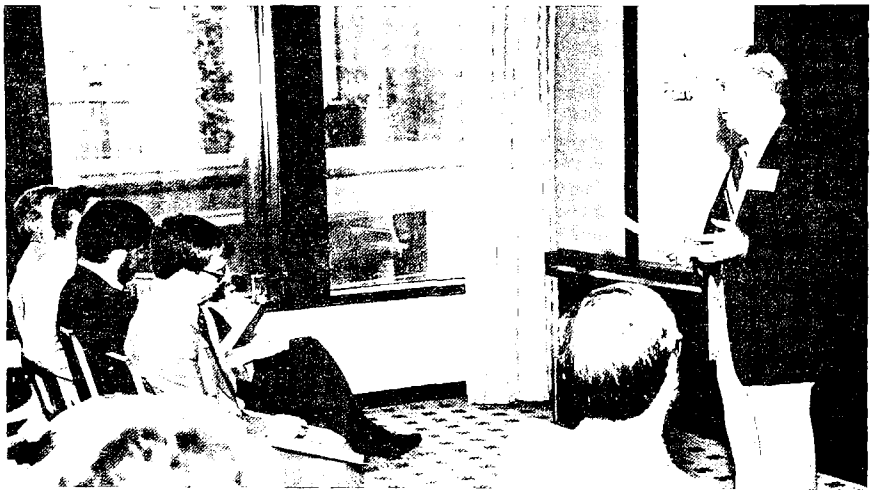
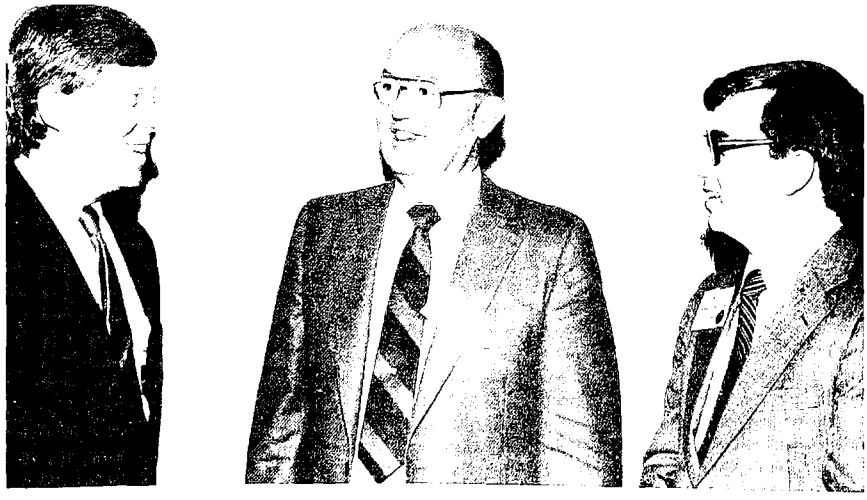
WSMA Annual Meeting: MSPC Members Participate

MSPC Members in attendance at the Annual WSMA meeting: Left to right, Drs. Bill Marsh, MSPC President Pat Duffy, Charles Anderson and Dick Bowe.



WSMA Speaker of the House of Delegates Dr. Stanley Tuell preparing members of the Reference Committees for their meetings.



U.S. Representative Richard A. Gephardt (D-Mo) (left) talking with MSPC President Dr. Pat Duffy (center) and Vice President Dr. Richard Hawkins at Annual WSMA meeting.

So, You Want to Sign a Contract

By Susan Hogeland, Assistant Executive Director,
San Francisco Medical Society

During a seminar for San Francisco Medical Society Leaders and staff, Richard Robinson, manager of the department of contract evaluations and negotiation services, offered a number of guidelines for physicians in dealing with contract analysis.

The November Bulletin *ran a short presentation on the issue of contracts in a reprint from San Francisco Medicine. The following article, reprinted with permission from the San Francisco Medicine, August 1983, outlines Robinson's presentation and provides a more in-depth report on the issue of contracts. As a follow-up,* The Bulletin *will be publishing in January an article by California Medical Association Legal Counsel David E. Willett on professional liability exposure.*

—the editor

Reprinted with permission from San Francisco Medicine, *August, 1983*

Look before you leap was the advice Richard Robinson gave physicians attending his seminar. Robinson told physicians they should read contracts before signing them. However, he explained that many of the seventy different contracts he had received for evaluation from physicians around the state (California) had already been signed when he got them. Notes were attached asking him to "take a look at this contract I have signed."

Amazing? Appalling? Unbelievable? Oh, yes. All the more frightening in light of the "worst case" analysis of the following fifteen clauses. Horrifying when it is known that over one hundred physicians in San Francisco signed and returned the now infamous first Blue Cross Prudent Buyer Plan contract without being asked.

Guidelines Recommended By Robinson

1. ***Scan the contract once in its entirety:*** What does it cover? Are the referenced materials attached? Often they are not, but when you sign, you agree to them anyway.

2. ***Perform a detailed, word-by-word analysis:*** Develop a list of the obligations you'll incur—do it on a word-by-word, paragraph-by-paragraph, or clause-by-clause basis.

Now determine what obligations the contracting entity has toward you, the physician.

Be sure to distinguish between mandatory (shall) and discretionary (may) terms, and pay special attention to the list of definitions in the contract. Who will be deciding what circumstances exist to meet those definitions?

3. ***Pay close attention to the utilization, peer and quality review terms of the contract:*** Thus far in Mr. Robinson's experience, it is rare that UR, peer and quality review requirements are spelled out or their terms defined. Often the contract adds insult to injury by *not* providing the terms and then noting the terms "may change from time to time."

He recommends referring *all* UR, peer and quality review clauses to your professional liability insurance company. The hold-harmless clause is a good example of the physician being asked to take on a responsibility which no insurer will cover.

4. ***Determine the economics of the contract:*** What is the financial track record of the entity wanting *your* signature on its contract. Can it provide a financial statement? If a company can't provide a certified financial statement—an ordinary procedure in business—your guard should be up.

5. *If* you sign, you agree only to what's in writing, not what the salesperson *said*.

Most contracts have a clause stating that only what is in writing counts. Further, oral representations that may be made by the entity's salespeople to make signing more attractive are not binding in court.

6. Send any new contract to your society and ask questions *before* you consider signing.

Sample Language From *Actual* Physician Contracts

1. *(Business entity) shall use its best efforts to encourage Members to use the services of PHYSICIAN.*

"Best efforts" is an undefined term. What is the company's financial record—does it have resources to promote the

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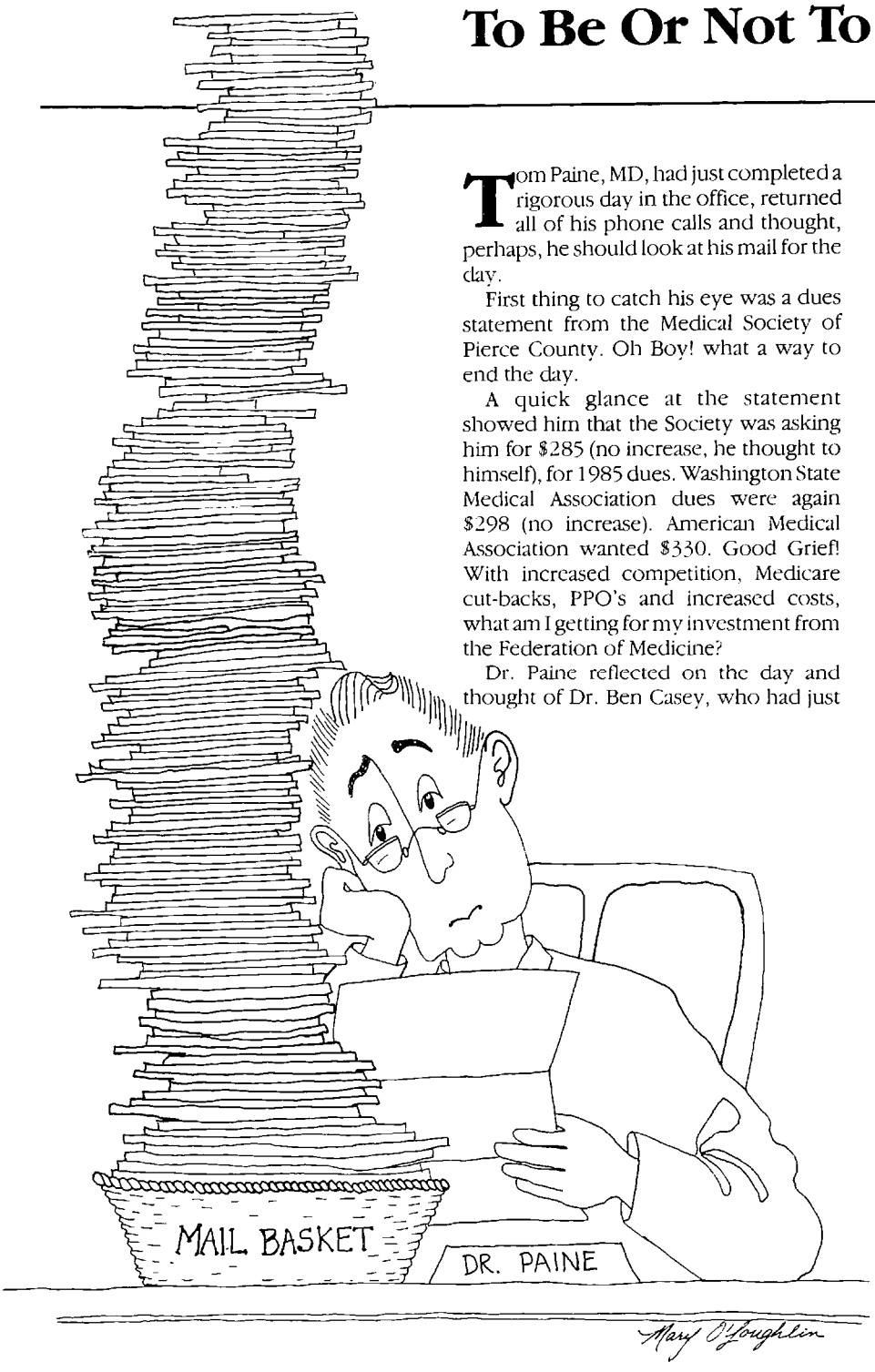
To Be Or Not To Be



Tom Paine, MD, had just completed a rigorous day in the office, returned all of his phone calls and thought, perhaps, he should look at his mail for the day.

First thing to catch his eye was a dues statement from the Medical Society of Pierce County. Oh Boy! what a way to end the day.

A quick glance at the statement showed him that the Society was asking him for $285 (no increase, he thought to himself), for 1985 dues. Washington State Medical Association dues were again $298 (no increase). American Medical Association wanted $330. Good Grief! With increased competition, Medicare cut-backs, PPO's and increased costs, what am I getting for my investment from the Federation of Medicine?

Dr. Paine reflected on the day and thought of Dr. Ben Casey, who had just joined the group. Ben had made application for membership in the Society, as well as applying for staff privileges in four hospitals in Pierce County.

He recalled Ben saying he was amazed at how simple the application process was with the Medical Society and Pierce County hospitals joining together to have created a uniform membership and hospital staff application.

Ben had discussed his appearance before the Credentials Committee of the Society with Dr. Paine. This process assures and protects the public from incompetent practitioners as well as protecting the profession.

All applications for medical staff membership at any of the Pierce County's eight hospitals are received and initially processed in the Medical Society's headquarters. Once the central file is established and the completed application received, certified copies of the application are forwarded to each of the hospitals with which Ben had indicated an interest in seeking staff privileges.

Dr. Paine was thinking of the new patient, Florence Nightenwin, who had come to his office that morning. He was curious about how she had chosen his office. He noticed on her history form that she had been referred to his office by the Medical Society's Patient Referral Service.

He had once heard that the Medical Society receives over 300 calls each month from individuals seeking assistance in securing a physician. Apparently, studies show that over 65 percent of those seeking referrals have insurance or the ability to pay.

Continuing to read his mail, Dr. Paine switched on the radio. He heard the announcer saying the American Medical Association had just filed a lawsuit against the government, protesting its actions against the medical profession concerning reimbursement for Medicare services.

He recalled not too long ago that the AMA had also initiated a suit to reverse the

"Baby Doe" decision and had fought hard to defeat the Kennedy-Gephardt Bill. Dr. Paine knew the Washington State Medical Association had been very active in seeking tort liability reform to control medical malpractice insurance rates, which had been increasing at an average rate of over 20 percent.

The WSMA was also working to correct a recent Attorney General's opinion that placed in legal limbo the status of approximately 18 allied health organizations.

In order for these groups to continue to perform such limited functions as injecting and withdrawing blood, legislation would have to be passed during this legislative session.

The WSMA was also instrumental in enacting implied consent laws to restrain drunk drivers and initiating public education programs to eradicate measles and other infectious childhood diseases.

Other recent successes of WSMA as an advocate in the State Legislature included: increasing Medicare reimbursement; an acceptance of a uniform claim form by most third party payers; enactment by the Legislature of a modern midwifery law; passage of legislation to guarantee the confidentiality of peer review committee records; and the defeat of most legislation to increase the scope and practice of allied health professions, which would permit direct patient referral.

In fact, Dr. Paine now carried "Physician's Insurance," established and sponsored by WSMA and owned by subscribing members. He knew "Physician's Insurance" provided an opportunity for physicians, not insurance executives, to determine their destiny in the escalating market.

In his mail stack Dr. Paine noted a request from the hospital in-service Director to do a program on his specialty for the hospital staff in three weeks. This did not concern him, to any great degree, because he knew he had available to him the resources of the Pierce County Medical Library, which he helped to support through his membership in the Medical Society.

He knew the library had inter-library contact with the University of Washington Medical School Library and would soon have a computer tie-in with FEDNET to provide information on medications, symptoms, nationwide bulletin boards, C.M.E. programs and the AMA legislative hotline.

There was a note on the top of the desk from his business manager. A receptionist who had been in the office for three years would be quitting in three weeks. This would mean placing an advertisement for a new receptionist, interviewing, testing and consuming much time.

He realized that the Medical Society, with its Placement Office in the Membership Benefits, Inc., would be able to assist him in seeking a staff replacement, just as they had two years ago.

The Placement Bureau is well informed concerning the needs of the physician and the physician's office. Their testing program would have the new receptionist prepared to go to work with a minimum amount of difficulty.

Continuing through his mail, Dr. Paine ran across an announcement for a Continuing Medical Education Program conducted in one of the local hospitals. The program was organized by the College of Medical Education, also supported by the Medical Society.

Dr. Paine had not given much thought lately to this service of the Medical Society. For several years, the College had been providing quality programs for him and his colleagues and had developed a reputation for providing some of the best C.M.E. in the Pacific Northwest. He knew all programs were developed with input from a committee of his colleagues on the more pertinent needs of the local medical community. The cost of the programs was nearly half of what physicians in other communities were paying to receive for category one credit.

The phone rang. Since his staff had long gone home, Dr. Paine answered. It was his exchange giving him a message from a patient. Dr. Paine's exchange was the Physician's Answering Service, a service endorsed by the Society and created to specifically serve the physician community with a staff trained to the particular needs of the physician.

The stack of mail was beginning to get smaller when he noticed the bright blue announcement for next month's General Membership Meeting of the Medical Society. He planned to attend the meeting knowing that it would deal with another important issue facing organized medicine in this era of dramatic change.

Dr. Paine recalled a recent General Membership program he attended where the emerging competitive climate was

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College of Medical Education
Continuing Education Programs Scheduled for 1984-85

(Programming is subject to change—individual notices will be sent preceding each program.)

Phone: 627-7137

(P) = Physician **(A)** = Allied Health

Location	Date	Program	Coordinator	
	DECEMBER			
JH	7, 8	Advanced Cardiac Life Support (Cert/Recert)	Dunn	(P/A)
	JANUARY			
STJ	17	Marketing to Win		
	17	Ear/Nose/Throat in General Practice	Wulfestieg/Rone	(P)
STJ	24	Law & Medicine	Malden	(P)
	FEBRUARY			
JH	7, 8	Orthopedics and Sports Medicine in Family Practice	Pomeroy/ Bargren	(P)
	TBA	Hospital Budgeting		(A)
	MARCH			
JH	14, 15	Tacoma Academy of Internal Medicine	Ames	(P)
JH	16	Day of Pediatrics/Poisoning	Scherz	(P)
	APRIL			
UPS	12, 13	Surgical Club	Martin	(P)
STH	TBA	Neurology	Overfield	(P)
	MAY			
JH	14	Common Office Procedures	Klatt	(P)
JH	23, 24	Cardiovascular Disease Review	Strait	(P)
	JUNE			
	TBA	TPN	Pelham	(P/A)
	TBA	Advanced Cardiac Life Support	Dunn	(P/A)

Dates are subject to change—Notification of each program will be mailed. Please contact the College of Medical Education office if you intend to register and/or have not received individual promotion.

For further information write or call: Maxine Bailey, Executive Director, COLLEGE OF MEDICAL EDUCATION
705 South 9th, No. 203, Tacoma, Washington 98405
Phone: (206) 627-7137

MARK YOUR CALENDAR — PLAN TO ATTEND

1985 Medical/Legal Seminar for Physicians and Attorneys

January 24, 1985 — St. Joseph Hospital, Tacoma

Sponsored by: *College of Medical Education*
together with
Medical Society of Pierce County
Pierce County Hospital Council

8:30	Informed Consent: What is it, How to obtain it, How to document it???? Don C. Pearson, M.D., J.D.
9:15	Vignettes of Recent Malpractice Cases Jack Rosenow, J.D.
10:00	Break
10:15	What to Look Out for in Contracts with Commercial Healthcare Providers? Keith Tucker, M.D., Pierce County Medical Bureau
11:00	When & How can Life Support be Withdrawn? Honorable Robert Peterson, J.D.
12:00	Lunch - Speaker: Honorable Vernon Pearson, J.D. "The Rule of Justice or The Rule of Law"
1:45	"Embarrassing" Questions in the Courtroom & How to Deal with Them? (A courtroom drama) Ross Burgess, J.D., Marcel Malden, M.D.
2:30	How to Deal with Child Protective Services & Other Agencies
3:15 to 4:00	Question/Answer

Program coordinator: Marcel Malden, M.D.

MARK YOUR CALENDAR — PLAN TO ATTEND

For further information and registration call
College of Medical Education - 627-7137

AUXILIARY NEWS

Fashion Show is grand success

Marny Weber and her committee did a very good job of planning the Medical Society Auxiliary style show held last month at the Tacoma-Sheraton Hotel. A capacity crowd previewed a spectacular parade of styles for all occasions presented by Andrews Apparel. Models were impressive as well. Thanks to auxilians Genny Hansen and Kit Larson who volunteered to model.

Donna Ferguson was the lucky winner of a $100 gift certificate donated by Andrews Apparel. Susie Duffy, Grace Kanda, Joanne Iverson and Norma Lloyd served on the committee with Marny Weber to make the day a grand success.

MSPC Auxiliary Members take part in volunteer training workshop

MSPC auxilians participated in a well-planned workshop Oct. 2 and 9. The workshop provided auxiliary members with information on volunteering, gave specific background information for working with new parents and outlined different management styles and how they effect communication. The Auxiliary thanks Family:Birth to Three Parent Support Program and Good Samaritan Mental Health Center for sponsoring the workshop.

Those participating in the training were: Cindy Anderson, Karen Crave, Dorothy Grenley, Carol Hopkins, Mildred Houglum, Sharon Ann Lawson, Debbie McAlexander, Ginnie Miller, Dorothy Truckey and Alice Willhyde. We are looking forward to working with parents soon.

Training sessions for specific aspects of the parenting program will be scheduled. If you are interested in volunteering, call Ginnie Miller or Sharon Ann Lawson.

Children's Holiday Party, Dec. 7 Magic Show to Highlight Festivities

Start the holiday season for your children and grandchildren with a fun party. Bring them to the Medical Auxiliary Children's Holiday Party, Friday, Dec. 7, from 4:00 P.M. to 5:30 P.M., University Place Presbyterian Church. All ages are welcome!

Highlighting the afternoon's activities will be a magic show presented by Dr. Harry Lawson and a visit from Santa. Bring a wrapped and labeled gift for a needy boy or girl.

Special Thanks to Our Tel-Med Volunteers

As a public service of the Pierce County medical Society Auxiliary in cooperation with the Medical Society of Pierce County, Tel-Med continues to provide a free telephone medical information service to the residents of Pierce County. The Tel-Med tape library has approximately 300 subjects from headaches to heart disease, from birth control to dandruff. The service is open for calls from 10 A.M. to 8 P.M. every weekday with Auxiliary volunteers taking calls from 10:00 A.M. to 12:30 P.M. throughout the year. Many members of the Auxiliary make up this group of volunteers, and with their help, Tel-Med continues to be a valuable community service.

Auxiliary volunteers are:

Dianna Ames
Carol Annest
Pat Annest
Marlene Arthur
Judy Baerg
Martha Bargren
Linda Bede
Karen Bloustine
*Dene Borg**
Alberta Burrows
Bonnie Cargol
*Terri Cotant**
Nikki Crowley
Marion Doherty
Susie Duffy
Beryl Ekman
Ane Fulcher
Sharron Gilbert
Jessie Gillespie
Marjorie Glock
Deloris Havlina
Julie Hoffmeister
Carol Hopkins
Sandra Irish
Mimi Jergens
Shirley Kemman
Miriam Kemp
Trudy Klatt
Sharon Lawson
Bernice Lazar
Marianne Lewis
Norma Lloyd
Carol Lovy
Sharon Lukens
Debbie McAlexander
Janice McIlroy
Georgia McPhee
Marilyn Mandeville
Barrie Mott
Kay North
*Nan Paris**
Elsie Parrott
Donna Prewitt
Dinnie Regalado
Marge Ritchie
Nancy Rose
Mary Schaeferle
Alaire Sheimo
Jeena Singh
Margaret Smith
Stephanie Tuell
Gloria Virak
Rubye Ward
Helen Whitney

**Dental Society Auxiliary Volunteers*

AMA-ERF Sharing Card

You will be receiving your Holiday Sharing Card from all the physicians and spouses in Pierce County who have generously contributed to this annual fund-raising project for our auxiliary. Cindy Anderson developed the card for the project. Nikki Crowley reported all our donations and listed the names for the printer. Tina Sobba coordinated merchandise sales for additional donations. Thank you, to all of them and to all of you for making this a great project. Look in next month's *Bulletin* for the total amount received towards this worth-while cause.

Attention Parents

Student Recognition Awards are available to all graduating seniors of physician families through the Auxiliary. Auxiliary members will be selling raffle tickets during the December 11 Annual Joint Dinner Meeting to raise funds for the awards. Encourage your child to apply. Applications will be available in all Pierce County high school counselor's offices in February. ■

To Be Or Not To Be, continued from page 15

discussed. He also remembered the opportunity he always had to meet and socialize with his colleagues at the meetings.

He valued the special meeting called for Society members alerting them about the Medicare reimbursement issue, creating "participating" and "non-participating" physicians. The meeting had HCFA officials on hand to help explain the changes mandated by the Federal government in the reimbursement of Medicare fees.

The discussion at that particular meeting had helped him reach a decision about whether to be a "participating" or "non-participating" physician. That meeting was the first that HCFA had had with the medical community in the state.

The next letter was a request for Dr. Paine to speak at one of the community civic organizations on the "Health Effects of Living in the ASARCO Plume."

The request had originated from Dr. Paine's volunteering to be a member of the Medical Society's Speaker's Bureau. He had enjoyed the opportunity to speak to one other group and a high school class on his specialty. He did think the Speaker's Bureau gave the Society and physicians good exposure to the community.

Nearing the end of his stack of mail, Dr. Paine opened a letter from the Medical Society's Chairman of the Ethics/Standards of Practice Committee. He had requested that the Ethics Committee review certain practices being undertaken by a fellow physician in regard to his advertising campaign.

The Ethics Committee reviewed the issue and concluded that the physician's advertising bordered on solicitation and requested that this discontinue. (It has.) The Ethics/Standards of Practice Committee had developed guidelines for medical practice that had been duplicated by many other county societies.

The last letter on the desk was from his colleague, Dr. Stanley Livingston, Chairman of the Grievance Committee. Dr. Paine was aware that a patient of another physician had filed a grievance against the physician concerning a certain procedure the physician had done on the patient three months ago. The Grievance Committee was asking Dr. Paine's view of the patient's condition prior to seeing the physician. The mediation of patients' complaints by the grievance Committee, he felt, had prevented several cases from going into litigation.

He could hear sirens in the background. If it was an emergency situation, Dr. Paine knew the patient would arrive at the hospital sooner and with greater chances of survival as a result of guidelines the Medical Society and its Emergency Medical Services (EMS) Committee had instituted. He was reassured knowing communication, para-medic training and transportation had all seen vast and continuing improvements.

Preparing to turn out the office lights, he noticed the dues statements on his desk still staring him in the face. He realized, in thinking things over, what a "bargain" membership really was as he sat down and wrote out a check to MSPC, WSMA and the AMA, recognizing that organized medicine represents the physician in many ways and that the benefits are many. ■

Report from the Department of Labor and Industries, continued from page 11

units must be stated as one unit for each time unit identified by the procedure. If the time unit on the procedure is equal to "each 15 minute", each 15 minute block is to be billed as one time unit. If time units are not on the bill, the system defaults to one and pays for one unit of service.

- *If you are the attending doctor, the Dx code is missing*

  OR

  If you are not the attending doctor, the referring doctor's name and Labor and Industries provider number is missing.

To assure payment, the following steps should be taken:

- *Be sure your bills have:*
  Claim number and claimant name;
  Your Department of Labor and Industries provider name and number;
  Procedure codes/modifiers;
  Units of service, if applicable;
  Diagnostic codes or referring provider name and number.
- *Consider tape-to-tape billing. The department has this option available. For information contact Bob Robinson at 1-206-743-1224.*
- *If you have pressing financial difficulties, Department of Labor and Industries staff will work with you. Contact Provider Services through the Toll-Free Line at 1-800-848-0811 or directly at 1-206-753-6372.* ■

Hospital News

St. Joseph

St. Joseph announces employee of the year

St. Joseph Hospital recently named Respiratory Therapist Dorothy Beers as Employee of the Year. The announcement was made at the annual Employee Awards Banquet at the Executive Inn in Fife.

Her supervisor Ric Radford, Director of Respiratory Therapy, says, "She does everything right; she helps others, is part of the backbone of our department and she's especially sensitive to patients."

The hospital selects an Employee of the Quarter throughout the year, based on criteria including professionalism, attitude, appearance and attendance. All Employees of the Quarter are eligible for selection as Employee of the Year.

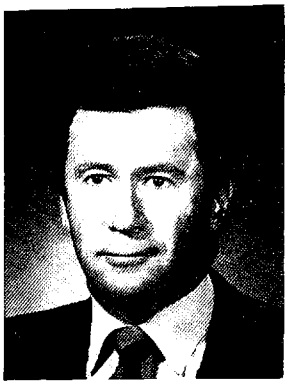
About the honor, Ms. Beers said, "I was very surprised to be chosen as Employee of the Year."

Ms. Beers graduated from the Respiratory Care Program, Tacoma Community College and has been employed by the hospital for 12 years.

The following information is
presented by Pierce County Medical Bureau.

The ALTERNATIVE

A Preferred Provider Plan



Bruce D. Buchanan, M.D.
Chairman, Board of Trustees,
Pierce County Medical Bureau

As I have stated previously, the purpose of these commentaries is to enhance communication between the Pierce County Medical Bureau and its participating physicians. As Chairman of the Board of Trustees for the Bureau, the feedback I have received from many of you has provided invaluable insight into your concerns about the status of the health care industry. Your comments, suggestions, and new ideas have been greatly appreciated and I hope the dialogue will continue.

The topic that has generated the greatest discussion in recent months is the Bureau's physician-designed preferred provider plan that will be available in 1985. Several large employer groups have expressed interest in this product and the Bureau's Marketing Department is particularly enthused about THE ALTERNATIVE's potential for attracting new business.

But the sense of excitement about, and confidence in, the preferred provider plan is not limited to Bureau staff and physicians, nor is it limited to Pierce County. Other bureaus have chosen to adapt our preferred provider design to their communities, which is certainly a compliment to the members of our Design Committee: Drs. Whitney, Doelle, Farber, Ferguson, Klatt, Lazar, McKelvey, Vitikainen and Virak.

These other bureaus are not only following our lead, but some of them are asking that our Preferred Physicians consider providing specialty or tertiary care that may not be available in their areas. This means that patients from other counties in Washington would be transferred to Pierce County for care, which would broaden our fields of practice.

In addition, we have been approached by physicians and physician groups from outside the county who are requesting preferred provider status with the Bureau. As a result of the interest this product has generated thus far, Pierce County Medical Bureau will be contacting other Blue Shield organizations within the state to propose a network of preferred providers. Such a network would be valuable to providers and patients alike.

Meanwhile, Karen Kiehn, Manager of Alternate Delivery Systems for the Bureau, reports steady progress toward actual implementation of THE ALTERNATIVE. Over 400 physicians and surgeons have signed Preferred Physician Agreements. The geographical distribution of these physicians meets the Bureau's requirements and all primary care and specialty fields are well represented. If you have not carefully considered the advantages of preferred status, I urge you to do so now.

Pierce County Medical is in the process of offering preferred status to other providers as well. A new state law allows certain arrangements with hospitals, which will enable the Bureau to ensure that preferred hospitals are cost-effective.

Please feel free to contact either Karen Kiehn or myself regarding THE ALTERNATIVE. As always, I welcome your comments or questions on this information or any other issues pertaining to Pierce County Medical Bureau.

Bruce D. Buchanan, M.D.
Chairman, Board of Trustees,
Pierce County Medical Bureau

Paid for by Pierce County Medical Bureau

So, You Want to Sign a Contract, continued from page 13

plan itself, does it intend to use a PR firm or have an advertising campaign?

Are there *members* to encourage? How will physicians be listed? Will physicians be required to pay a fee to join the program? Will these fees be used to market the plan or finance the lifestyle of the top program executives?

How will physicians know *if* the plan is using its best efforts? Is there any means to enforce such behavior? How would physicians prove the plan *didn't* use its best efforts?

This clause is vague, ambiguous and meaningless. Initially, however, it could be attractive to physicians.

2. *(Business entity) and PHYSICIAN agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement.*

This is a nice, gentlepersonly, honorable clause. Very attractive.

However, the terms meet and confer mean nothing. The clause does not say *negotiate*. There is no mutual obligation to resolve differences. In fact, the use of the telephone could be sufficient to meet the requirements of this clause.

The language implies there is a process by which disputes will be resolved—but no such process is spelled out.

3. *PROVIDER agrees: (1) to participate in the peer and utilization review programs (including prior authorization of hospitalization and elective surgery, concurrent and retrospective review) developed from time to time by (business entity). . .*

This language is quite typical—nothing is spelled out in detail. What does "participate" mean? Do you do it yourself? Develop it? Are you bound by it? Peer review and utilization review are undefined. How complex will prior authorization be?

The clause is broad, vague, ambiguous and potentially frightening from a professional liability viewpoint.

Finally, if the physician participates in the entity's utilization review, and a particular service is denied to a patient, that patient may sue the provider as well as the reviewer.

4. *PROVIDER agrees that should it enter into a contract with another PPO or similar entity during the terms of this AGREEMENT, then PROVIDER will (1) notify (business entity) of such participation and (2) should payment (fees) for PROVIDER under such contract be lower than those identified in Schedule A attached hereto, then such lower payment (fees) shall also apply for the duration of the AGREEMENT.*

This clause may be anticompetitive. What is a "PPO?" What's a "similar entity?" What is participation?

This clause points out the impact that signing one contract could have on signing others.

5. *PROVIDER agrees to cooperate with the peer review process of (business entity) as conducted by its Clinical Services Management Committee (CSMC), and to abide by the rules and recommendations of that Committee.*

This clause moves you from "participate" (see 3) to "cooperate" and "abide." What is the makeup of the clinical services management committee—what is the membership; what are the rules; what are the procedures?

6. *PROVIDER agrees to abide by such rules and regulations pertaining to this contract as may be adopted from time to time by the Board of Directors of (business entity).*

This is a typical, open-ended clause that means a physician who signs such a contract would agree *blindly* to whatever the business entity chooses to do in the future. There is no specificity regarding *what* the rules might pertain to.

The clause opens the door to blatant contract modification by the entity on a de facto basis. For example: "medical

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MEMBERSHIP

In accordance with the Bylaws of the Medical Society of Pierce County, Chapter Seven, Section A, MEMBERSHIP, the following physicians have applied for membership, and notice of their application is herewith presented.

As outlined in the Bylaws, any member who has information of a derogatory nature concerning an applicant's moral or ethical conduct, medical qualifications or other such requisites for membership, shall assume the responsibility of conveying that information to the Credentials Committee or Board of Trustees of the Society.

Steven G. Buty, MD, *Ob-Gyn.* Born 12/31/48; medical school, Univ. of Washington, Seattle, WA, 1980; internship, Family Medicine of Spokane, 1980-81; residency, Sacred Heart Med. Ctr., 1981-84. Washington State License, 1984. Dr. Buty is currently practicing at South 36th and Pacific, Tacoma, Washington.

Elsie T. Claypool, MD, *Administrative Medicine.* Born in East Lyme, CT, 9/20/25; medical school, Medical College of Penn., 1951; internship, Univ. of Texas Medical Branch, 7/51-6/52; residency, Univ. of Texas Medical Branch, Pediatrics, 7/52-6/54. Washington State License, 1984. Dr. Claypool is currently practicing administrative medicine at 1520 3rd Avenue, Seattle, Washington.

John O. Goodin, MD, *Ophthalmology.* Born in Palo Alto, CA, 5/8/45; medical school, Medical College of Georgia, Augusta, GA, 6/5/71; internship, medicine and Ob-Gyn, Baylor Univ. Medical Center, 7/71-6/72; residency ophthalmology, Letterman Army Med. Ctr. and Walter Reed Army Med. Ctr., 7/76-6/79. Washington State License, 1984. Dr. Goodin is currently practicing at 521 South "K" Street, Tacoma, Washington.

Allan Berggren, MD, *Ear, Nose & Throat/Head and Neck Surgery.* Born in Holdrege, Nebr., 7/8/37; medical school, Case Western Reserve Univ., 1963; internship, St. Luke's Hospital, Cleveland, OH, 7/63-6/64; residency, St. Luke's Hospital, Cleveland, OH, ENT-7/64-6/65 & General Surgery-7/65-4/66. Washington State License, pending. Dr. Berggren is currently practicing at 124 Tacoma Avenue, Tacoma, Washington.

Robert D. Flack, MD, *Family Practice.* Born in Sabetha, KS, 5/30/47; medical school, Univ. of Texas Medical Branch, Galveston, TX, 5/77; internship, Univ. of Missouri Medical School, Columbia, MO, 7/77-7/78; residency, Univ. of Missouri Med. School, Columbia, MO, 7/78-7/80. Washington State License, pending. Dr. Flack is currently practicing at 1112 South Cushman Avenue, Tacoma, Washington.

Janice Strom, MD, *Internal Medicine.* Born in South Bend, IN, 11/24/51; medical school, Univ. of Louisville, Louisville, KY, 1978; internship, internal med., Univ. of Louisville Affil. Hospital, Louisville, KY, 7/78-6/79; residency, internal medicine, East Carolina School of Med., Pitt Mem. Hospital, Greenville, NC, 7/79-6/81; graduate training, geriatrics, Duke Univ. Med. Ctr., Durham, NC, 7/82-6/83. Washington State License, 1983. Dr. Strom is currently practicing at A-233 Allenmore Med. Center, Tacoma, Washington.

Michael Cherkassky, MD, *Internal Medicine.* Born in USSR, 12/31/44; medical school, Astrachan Medical School, Astrachan, USSR, 1975; internship, Brooklyn-Cumberland Med. Ctr., Brooklyn, NY, 7/78-7/79; residency, Brooklyn-Cumberland Med. Ctr., Brooklyn, NY, 7/79-7/81; graduate training, Hematology, Univ. Mass. Med. Ctr., Worcester, MA, 7/81-7/82; Albany Med. School, Albany, NY, 7/82-7/83; Oncology, State Univ. of NY, V.A. Med. Ctr., Brooklyn, NY, 7/83-7/84. Washington State License, 1984. Dr. Cherkassky is currently practicing at South 36th and Pacific, Tacoma, Washington.

Jean B. Goerss, MD, *Pediatrics.* Born in New York, 7/1/56; medical school, Loyola-Stritch, Maywood, IL, 6/81; internship, pediatrics, Mayo Clinic, Rochester, MN, 6/81-6/82; residency, pediatrics, Mayo Clinic, Rochester, MN, 6/82-6/84. Washington State License, 1984. Dr. Goerss is currently practicing at #3 Professional Building, Gig Harbor, Washington.

So, You Want to Sign a Contract, continued from page 24

necessity" could be defined *after* you sign. Advertising and marketing programs could market *you* in any way they chose under this provision.

7. *PROVIDER agrees to comply with and be bound by the bylaws, rules, regulations and policies of (business entity) as they now exist and which may hereafter be adopted or amended from time to time by the Board of Directors or by the Members.*

This language is similar to that in 6. You are being asked to sign *before* you know the rules of the game. Demand to see the bylaws, policies, etc.

8. *PROVIDER shall recommend to patients in order to promote cost control that they use other participating PROVIDERS in the service area in which the patient resides and agrees not to refer patients to non-participating PROVIDERS without prior authorization of PPO.*

This is a mandatory clause—"shall recommend." How many times must the physician recommend? How firm must he or she be? What if the services of a non-participating MD are required? How long will the authorization process take? How will the patient respond to delay?

How is the physician to know who all the "participating providers" are? What if a physician is placed on the list by mistake and is actually not a signatory? What is the "service area?" What are the penalties for *not* recommending a participating provider?

9. *(Business entity) will make payment of all approved claims. . .*

Who will approve the claims? This clause does not add "consistent with the attached fee or procedure schedule." The entity does the approving which opens the way for arbitrary and capricious action. Is there an appeals process or a time frame for approval?

10. *PROVIDER agrees that the provisions of this agreement are subject to amendment by (business entity) from time to time upon thirty (30) days' written notice to PROVIDER and that PROVIDER shall thereafter be bound by the provisions as so amended provided, however, that if PROVIDER delivers to (business entity) at any time during such thirty (30) day period written notice of PROVIDER's election to terminate this Agreement, this Agreement shall immediately so terminate.*

This is the "take it or leave it" clause. Either a provider agrees to an open-ended amendment procedure or he or she bails out. The thirty day time frame could have potential professional liability implications. What does the physician have to do to notify his or her patients that they can no longer be treated? Will the physician have to inform patients that if they continue with the office they might be asked to pay part of the fee? Is there an obligation for the physician to continue to treat patients when the physician is no longer with the plan? The obligation to the patient transcends the contract in every case.

continued on following page

So, You want to Sign a Contract, continued from previous page

This clause permits the entity to materially alter the original agreement — including the fee schedule.

11. *PROVIDER shall have the right to appeal any determination by PPO relating to matters governed by this Agreement. PROVIDER's right to appeal shall be pursuant to appeals procedures established by PPO.*

This clause gives physicians the right to appeal, but the PPO has the responsibility for developing and implementing the appeal procedures. The physician is not told what administrative procedures must be exhausted before the appeal process can be utilized. The procedure could be lengthy and costly. In some contracts, if the physician loses the appeal, he or she must pay the legal fees for the PPO.

12. *(Business entity's) relationship with the PROVIDER is based on trust. The only way (business entity) can monitor a PROVIDER is through patient complaints. Serious or numerous complaints, after being reviewed with PROVIDER, will be cause for removal from the (business entity) provider directory.*

This clause presumes the physician's guilt—it states that complaints "will be cause" for review/removal. It does not delineate any review process.

The clause has emotional appeal but it is meaningless. What is "serious?" What is "numerous?"

The clause opens the door for abuse by the entity—complaints could actually be encouraged, no matter how frivolous. No due process is provided.

13. *PROVIDER agrees to abide by such additional review programs and procedures as may be developed from time to time by (business entity).*

This is another open-ended clause which permits the entity to make any changes it wishes in the original contract.

14. *The physician hereby covenants and agrees as follows: . . . (b) to provide for the availability of medical services at such times and in such locations within the Service Area as shall be necessary and practical for the prompt and proper rendition thereof. . .*

(b)—Can the entity establish your hours? your location? What are "medical services?" Are they in your office, in the emergency room, do they include house calls? Must you provide services 365 days per year, 24 hours per day? What is the service area? What do you have to cover geographically?

This clause is vague and open-ended. It is designed to shift liability to the provider. If it takes the entity six months to develop a directory, how do you know to whom to refer? What if you and six other physicians are the only ones who sign up? How do you meet your responsibilities under this clause?

15. *I will refer to panel providers for services. If no contracted provider is available I will notify patient that he will be responsible for standard policy copayments.*

The PPO is letting the physician be the bearer of bad news—the MD gets to tell the patient there is no panel provider to whom to refer the patient. Therefore, the patient has to pay out-of-pocket for services if he or she wants them.

If the directory of panel providers is at all outdated, there is the possibility the physician could refer the patient to a doctor who is no longer signed up. What is the physician's liability then?

How will the patient be notified that he or she will be responsible for the standard policy copayments? How far must the physician go? ■

CLASSIFIED

View Home: Gig Harbor - Now $120,000 by owner. I've slashed $16,000 off the price on this 2,800 sq. ft., 3 bedroom home with many amenities. Must sell by summer. Call George, 1-851-5248.

Lakewood Medical Dental Building -1,500 sq. ft. on Steilacoom Blvd. High visibility. Finish to suit your needs. Call Roger Lundstrom at 206-584-2000 for further information. LUNDSTROM, INC. 9618 Gravelly lake Dr., S.W., Tacoma, WA.

Used Store Furniture - Lowboy displays, revolving card racks, plexiglass displays. Call 272-9096.

For Sale - Medical Clinic and Practice in Parkland. 1,600 sq. ft., includes X-ray, minor surgery and large examining rooms. Contact J. J. Erickson, MD, P.O. Box 44488, Tacoma, WA 98444

1984 Mercedes 300 D - New, Loaded. Negotiable price. Call Madeline 582-7896.

Physician Opening - Prefer Board Eligible or Certified Family Practitioner, Emergency Physician or Internist with interest in acute care for ambulatory/minor emergency center. Position is half to two-thirds time with excellent scheduling. Contact Roger Simms, MD or Terry Kendrick, MD, at 5702 N. 26th Street, Tacoma, WA, 98407. Telephone (206) 759-6655.

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TIMELESS ELEGANCE!! 2 Acre Lakewood Estate on Clover Creek. Vaulted ceiling in family room, 4 bedrooms, 5 baths, marble fireplace in Master Suite. 4,100 Sq.Ft., parklike grounds. $325,000. **Marge McCulloch** 588-7424 res., 582-6111 ofc. #61469.

OUTSTANDING ARCHITECT designed home on nearly 1 Acre in prestigious LAKEWOOD area. Cathedral ceiling, clerestory windows, 4 bedrooms, 3½ baths, family room w/wet bar, gourmet kitchen, formal dining room, sunken living room. Many unique features to enhance family living. Call **Janice Ludwig** 584-5066 res., 582-6111 ofc. #69359.

AMERICAN LAKE ESTATE: A 4 Acre Estate featuring 360 foot no bank Lakefront and impeccable professional landscaping. Top quality 5 bedrooms, 4 bath residence. Call **Al Dunken** for an appointment 582-0991 res., 582-6111 ofc. #69008.

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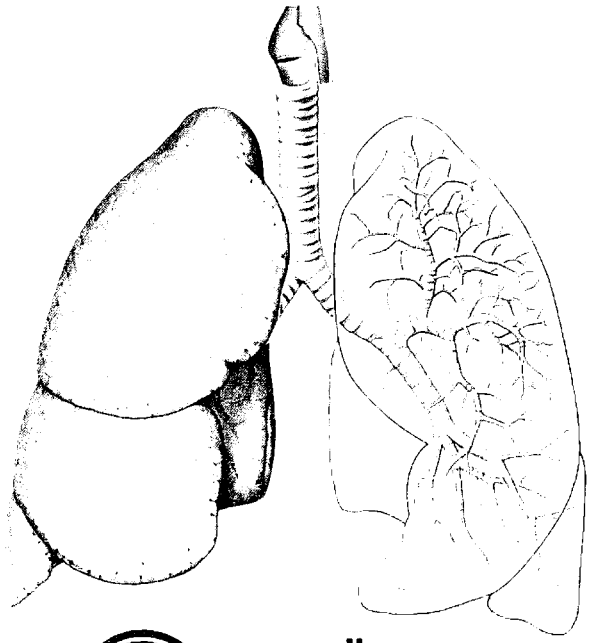

Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) **(ampicillin-resistant)**

Brief Summary: Consult the package literature for prescribing information

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD ILL REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* – If an allergic reaction to Ceclor (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions, and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers – Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 1500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Caolina, Puerto Rico 00630

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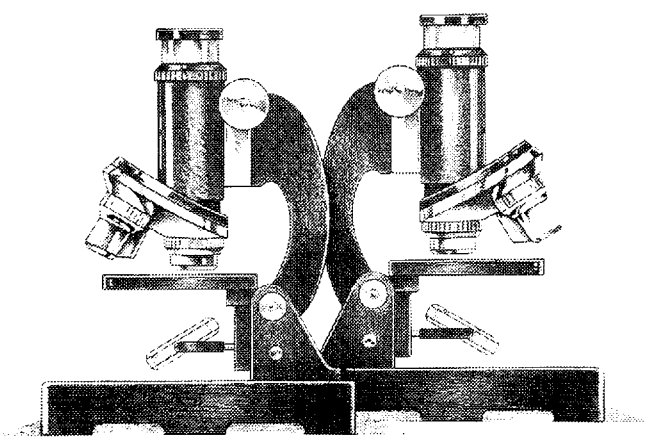

In response to employer demand for cost containment programs, Blue Cross of Washington and Alaska is now implementing the Second Surgical Opinion Program (SSOP) and the Outpatient Surgery Program (OSP).

Mandatory Second Opinions. With SSOP, Blue Cross requires its subcribers seek a second surgical opinion after surgery is recommended by a physician, though the second opinion need not be confirming.

SSOP applies to elective, non-emergency procedures only. The Plan pays 100% of UCR for all required second opinions.

Outpatient Surgery. For groups that have the OSP, Blue Cross requries that certain elective procedures be performed on an outpatient basis or be precertified for inpatient.

Outpatient Settings. Outpatient surgery may be performed in a doctor's office, free-standing surgical center, or hospital outpatient location.

Benefit Requirement. SSOP and OSP requirements must be followed or the subscriber will be financially responsible for the primary surgeon's fee.

For a brochure and complete list of SSOP/OSP forms and procedures, contact Blue Cross Customer Service at P.O. Box 327, Seattle, Washington 98111.

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